SERFF Tracking Number:	*ASWX-125719472*	*State:*	*Arkansas*
Filing Company:	*Time Insurance Company*	*State Tracking Number:*	*39500*
Company Tracking Number:	*IHAR00246FIF02*		
TOI:	*H16I Individual Health - Major Medical*	*Sub-TOI:*	*H16I.005C Individual - Other*
Product Name:	*Time Insurance-Base Chassis*		
Project Name/Number:	*Time Insurance-Base Chassis/IH AR00246FIF02*		

Filing at a Glance

Company: Time Insurance Company

Product Name: Time Insurance-Base Chassis	SERFF Tr Num: ASWX-125719472	State: ArkansasLH
TOI: H16I Individual Health - Major Medical	SERFF Status: Closed	State Tr Num: 39500
Sub-TOI: H16I.005C Individual - Other	Co Tr Num: IHAR00246FIF02	State Status: Approved-Closed
Filing Type: Form	Co Status:	Reviewer(s): Rosalind Minor
	Author: SPI AssurantHealthandEmployeeBenef	Disposition Date: 07/07/2008
	Date Submitted: 07/01/2008	Disposition Status: Approved-Closed
Implementation Date Requested: 07/29/2008		Implementation Date:

State Filing Description:

General Information

Project Name: Time Insurance-Base Chassis	Status of Filing in Domicile:
Project Number: IH AR00246FIF02	Date Approved in Domicile:
Requested Filing Mode: Review & Approval	Domicile Status Comments:
Explanation for Combination/Other:	Market Type: Individual
Submission Type: New Submission	Group Market Size:
Overall Rate Impact:	Group Market Type:
Filing Status Changed: 07/07/2008	
State Status Changed: 07/07/2008	Deemer Date:

Corresponding Filing Tracking Number:

Filing Description:

REVISIONS TO PREVIOUSLY APPROVED FORMS

TIME INSURANCE COMPANY (NAIC #69477; FEIN 39-0658730)

Certificate Amendment Rider (05/2008 Edition): TIM.6044.AR

Benefit Summary (05/2008 Edition): TIM.BNC.AR

Condition Specific Deductible Endorsement CSD.001.XX

Special Exception Rider SER.001.XX

SERFF Tracking Number:	*ASWX-125719472*	*State:*	*Arkansas*
Filing Company:	*Time Insurance Company*	*State Tracking Number:*	*39500*
Company Tracking Number:	*IHAR00246FIF02*		
TOI:	*H16I Individual Health - Major Medical*	*Sub-TOI:*	*H16I.005C Individual - Other*
Product Name:	*Time Insurance-Base Chassis*		
Project Name/Number:	*Time Insurance-Base Chassis/IH AR00246FIF02*		

Company Reference No.: IHAR00246FIF02

The above-referenced revisions to our Benefit Summary form are hereby submitted for your review and approval.

Benefit Summary form JIM.BNC.AR, revised 05/2008, replace form JIM.BNC.AR in its entirety. Benefit Summary form JIM.BNC.AR was previously approved by the Department on October 26, 2005.

Company and Contact

Filing Contact Information

Christine Fleming, Senior Contract Compliance Analyst	christine.fleming@assurant.com
501 W. Michigan St.	(414) 299-1306 [Phone]
Milwaukee, WI 53203	(414) 299-6168[FAX]

Filing Company Information

Time Insurance Company	CoCode: 69477	State of Domicile: Wisconsin
501 W. Michigan St.	Group Code: 19	Company Type:
Milwaukee, WI 53203	Group Name:	State ID Number:
(800) 800-1212 ext. [Phone]	FEIN Number: 39-0658730	

Filing Fees

Fee Required?	Yes
Fee Amount:	$20.00
Retaliatory?	No
Fee Explanation:	
Per Company:	No

COMPANY	AMOUNT	DATE PROCESSED	TRANSACTION #
Time Insurance Company	$20.00	07/01/2008	21199965

SERFF Tracking Number:	*ASWX-125719472*	*State:*	*Arkansas*
Filing Company:	*Time Insurance Company*	*State Tracking Number:*	*39500*
Company Tracking Number:	*IHAR00246FIF02*		
TOI:	*H16I Individual Health - Major Medical*	*Sub-TOI:*	*H16I.005C Individual - Other*
Product Name:	*Time Insurance-Base Chassis*		
Project Name/Number:	*Time Insurance-Base Chassis/IH AR00246FIF02*		

Correspondence Summary

Dispositions

Status	Created By	Created On	Date Submitted
Approved-Closed	Rosalind Minor	07/07/2008	07/07/2008

SERFF Tracking Number:	*ASWX-125719472*	*State:*	*Arkansas*
Filing Company:	*Time Insurance Company*	*State Tracking Number:*	*39500*
Company Tracking Number:	*IHAR00246FIF02*		
TOI:	*H16I Individual Health - Major Medical*	*Sub-TOI:*	*H16I.005C Individual - Other*
Product Name:	*Time Insurance-Base Chassis*		
Project Name/Number:	*Time Insurance-Base Chassis/IH AR00246FIF02*		

Disposition

Disposition Date: 07/07/2008
Implementation Date:
Status: Approved-Closed
Comment:

Rate data does NOT apply to filing.

SERFF Tracking Number:	*ASWX-125719472*	*State:*	*Arkansas*
Filing Company:	*Time Insurance Company*	*State Tracking Number:*	*39500*
Company Tracking Number:	*IHAR00246FIF02*		
TOI:	*H16I Individual Health - Major Medical*	*Sub-TOI:*	*H16I.005C Individual - Other*
Product Name:	*Time Insurance-Base Chassis*		
Project Name/Number:	*Time Insurance-Base Chassis/IH AR00246FIF02*		

Item Type	Item Name	Item Status	Public Access
Supporting Document	Certification/Notice	Approved-Closed	Yes
Supporting Document	Application	Approved-Closed	Yes
Supporting Document	Health - Actuarial Justification	Approved-Closed	Yes
Supporting Document	Outline of Coverage	Approved-Closed	Yes
Supporting Document	Cover Letter	Approved-Closed	Yes
Supporting Document	Forms List	Approved-Closed	Yes
Supporting Document	Marked Benefit Summary	Approved-Closed	Yes
Supporting Document	Marked Amendment 6044	Approved-Closed	Yes
Form	Certificate Amendment Rider (5/2008)	Approved-Closed	Yes
Form	Condition Specific Deductible Endorsement	Approved-Closed	Yes
Form	Special Exception Rider	Approved-Closed	Yes
Form	Benefit Summary	Approved-Closed	Yes
Form	Outline of Coverage	Approved-Closed	Yes

SERFF Tracking Number:	*ASWX-125719472*	*State:*	*Arkansas*
Filing Company:	*Time Insurance Company*	*State Tracking Number:*	*39500*
Company Tracking Number:	*IHAR00246FIF02*		
TOI:	*H16I Individual Health - Major Medical*	*Sub-TOI:*	*H16I.005C Individual - Other*
Product Name:	*Time Insurance-Base Chassis*		
Project Name/Number:	*Time Insurance-Base Chassis/IH AR00246FIF02*		

Form Schedule

Lead Form Number: TIM.6044.AR

Review Status	Form Number	Form Type	Form Name	Action	Action Specific Data	Readability	Attachment
Approved-Closed	TIM.6044.AR	Certificate Amendment, Insert Page, Endorsement or Rider	Certificate Amendment Rider (5/2008)	Initial		50	TIM_6044_AR.PDF
Approved-Closed	CSD.001.XX	Certificate Amendment, Insert Page, Endorsement or Rider	Condition Specific Deductible Endorsement	Initial		47	CSD_001_XX.PDF
Approved-Closed	SER.001.XX	Certificate Amendment, Insert Page, Endorsement or Rider	Special Exception Rider	Initial		49	SER_001_XX.PDF
Approved-Closed	TIM.BNC.AR	Schedule Pages	Benefit Summary	Initial		52	TIM_BNC_AR.PDF
Approved-Closed	TIM.OCC.AR	Outline of Coverage	Outline of Coverage	Initial		0	TIM_OCC_AR.PDF

Time Insurance Company
501 West Michigan
Milwaukee, WI 53203

CERTIFICATE AMENDMENT RIDER (05/2008)

The following amendments will be incorporated into the certificate of medical insurance (form TIM.CER.AR, which was previously approved by your Department on October 25, 2005).

The bulleted headers (in bold/italics) will identify if the language will be added, removed or replaced/modified.

FORM TIM.CER.AR AMENDMENTS:

- ***DEF: 155.003.GE is replaced with DEF: 155.003.001.GE, which reads as follows:***

[**Dependent**
A Dependent is:

[1.] The Certificate Holder's lawful spouse[, including the Certificate Holder's Domestic Partner] [if recognized under applicable law]; or

[2.] [The Certificate Holder's naturally born child, legally adopted child, a child that is placed for adoption with the Certificate Holder, a stepchild or a child for which the Certificate Holder is the legal guardian:

[a.] [Who is unmarried; and]
[b.] [Who is age [18] or younger; and]
[c.] [Who is claimed as an exemption on Your most recent federal income tax return, except for a Dependent child who is a full-time student; and]
[d.] [Whose legal address is the same as the Certificate Holder's legal address].]

[If the child's legal address is different than the Certificate Holder, the child will be considered a Dependent if You submit proof that:

[a.] [You are required by a qualified medical child support order to provide medical insurance; or]
[b.] [The child was claimed as an exemption on Your most recent federal income tax return].]

[If Your unmarried child is age [19] or older, the child will be considered a Dependent if You give Us proof that:

[a.] [The child is a full-time student at an accredited educational institution, college or university. A student will be considered full-time if the student meets the standards for full-time status at the school the student is attending. A student will be considered full-time during regular vacation periods that interrupt, but do not terminate, the continuous full-time course of study; or]
[b.] [The child is not capable of self-sustaining employment or engaging in the normal and customary activities of a person of the same age because of mental incapacity or physical handicap. The child must also be chiefly dependent on the Certificate Holder for financial support [and be claimed as an exemption on Your most recent federal income tax return]. You

must give Us proof that the child meets these requirements at the same time that You first enroll for coverage under this plan [or within [31] days after the child reaches the normal age for termination]. Additional proof may be requested periodically [but not more often than annually after the [2-year] period following the date the child reaches the normal age for termination].]

[A child will no longer be a Dependent on the earliest of the date that he or she:

[a.] [Is no longer a full-time student; or]
[b.] [Graduates; or]
[c.] [Ceases to be claimed as an exemption on the Certificate Holder's federal income tax return, except for a Dependent child who is a full-time student; or]
[d.] [Attains age [24]; or]
[e.] [Marries; or]
[f.] [Is over age [18] and is capable of self-sustaining employment because he or she is no longer mentally incapacitated or physically handicapped[.][; or]]
[g.] [Or You request their coverage be terminated.]

[This plan terminates in accordance with the Termination Date of Coverage provision.]

[If only Dependent children are covered under this plan, the youngest child will be considered the Certificate Holder. All siblings of the Certificate Holder will be considered Covered Dependents if they meet the requirements above.]]

DEF: 155.003.001.GE

- ***DEF: 155.007.GE is replaced with DEF: 155.007.001.GE, which reads as follows:***

[**Dependent**
A Dependent is:

[1.] [The Certificate Holder's lawful spouse[, including the Certificate Holder's Domestic Partner] [if recognized under applicable law]; or]

[2.] [The Certificate Holder's naturally born child, legally adopted child, a child that is placed for adoption with the Certificate Holder, a stepchild or a child for which the Certificate Holder is the legal guardian:

[a.] [Who is unmarried][; and]
[b.] [Who is chiefly dependent on the Certificate Holder for financial support].]

[A child will no longer be a Dependent on the earliest of the date that:

[a.] [He or she marries][;]

[b.] [He or she is no longer chiefly dependent on the Certificate Holder for financial support][; or]
[c.] [He or she or the Certificate Holder request their coverage be terminated.]]

[This plan terminates in accordance with the Termination Date of Coverage provision.]

[If only Dependent children are covered under this plan, the youngest child will be considered the Certificate Holder. All siblings of the Certificate Holder will be considered Covered Dependents if they meet the requirements above.]]
DEF: 155.007.001.GE

- ***DEF: 235.001.GE is replaced with DEF: 235.001.001.GE, which reads as follows:***

[**Experimental or Investigational Services**
Treatment, services, supplies or equipment which, at the time the charges are Incurred, We determine are:

1. Not proven to be of benefit for diagnosis or treatment of a Sickness or an Injury; or

2. Not generally used or recognized by the medical community as safe, effective and appropriate for diagnosis or treatment of a Sickness or an Injury; or

3. In the research or investigational stage, provided or performed in a special setting for research purposes or under a controlled environment or clinical protocol; or

4. Obsolete or ineffective for the treatment of a Sickness or an Injury; or

5. Medications used for non-FDA approved indications and/or dosage regimens.

For any device, drug, or biological product, final approval must have been received to market it by the Food and Drug Administration (FDA) for the particular Sickness or Injury. However, final approval by the FDA is not sufficient to prove that treatment, services or supplies are of proven benefit or appropriate or effective for diagnosis or treatment of a Sickness or an Injury. Any approval granted as an interim step in the FDA regulatory process, such as an investigational device exemption or an investigational new drug exemption, is not sufficient.

Only We can make the determination as to whether charges are for Experimental or Investigational Services based on the following criteria:

1. Once final FDA approval has been granted, the usage of a device for the particular Sickness or Injury for which the device was approved will be recognized as appropriate if:

    a. It is supported by conclusive evidence that exists in clinical studies that are published in generally accepted peer-reviewed medical literature or review articles; and
    b. The FDA has not determined the medical device to be contraindicated for the particular Sickness or Injury for which the device has been prescribed.

2. Once final FDA approval has been granted, the usage of a drug or biological product will be recognized as appropriate for a particular Sickness or Injury if the FDA has not determined the drug or biological product to be contraindicated for the particular Sickness or Injury for which the drug or biological product has been prescribed and the prescribed usage is recognized as appropriate medical treatment by:

   a. The American Medical Association Drug Evaluations; or
   b. The American Hospital Formulary Service Drug Information; or
   c. Conclusive evidence in clinical studies that are published in generally accepted peer-reviewed medical literature or review articles.

3. For any other treatment, services or supplies, conclusive evidence from generally accepted peer-reviewed literature must exist that:

   a. The treatment, services or supplies have a definite positive effect on health outcomes. Such evidence must include well-designed investigations that have been reproduced by non-affiliated authoritative sources, with measurable results, backed up by the positive endorsements of national medical bodies or panels regarding scientific efficacy and rationale; and
   b. Over time, the treatment, services or supplies lead to improvement in health outcomes which show that the beneficial effects outweigh any harmful effects; and
   c. The treatment, services or supplies are at least as effective in improving health outcomes as established technology, or are useable in appropriate clinical contexts in which established technology is not employable.]

DEF: 235.001.001.GE

- ***DEF: 335.008.GE is added:***

[6.] [**Retail Health Clinic:** A facility that meets all of the following requirements:

   [a.] [[Be licensed by] [or] [operate pursuant to] the state in accordance with the laws for the specific services being provided in that facility;]
   [b.] [Be staffed by a Health Care Practitioner in accordance with the laws of that state;]
   [c.] [Is [attached to] [or] [part of] a store or retail facility;]
   [d.] [Is separate from a[n] [Acute Medical Facility [(Hospital)]][, Emergency Room][, Acute Medical Rehabilitation Facility][, Free-Standing Facility][, Skilled Nursing Facility][, Subacute Rehabilitation Facility,] [or] [Urgent Care Facility] [and any Health Care Practitioner's office located therein,] [even when services are performed after normal business hours;]]
   [e.] [Provides general medical treatment or services for a Sickness or Injury[, or provides preventive medicine services,] [on a non-seasonal basis;] [and]
   [f.] [Does not provide room and board or overnight services.]]

DEF: 335.008.GE

- ***DEF: 400.001.GE is replaced with DEF: 400.001.001.GE, which reads as follows:***

[**Office Visit**
A[n in-person] meeting between a Covered Person and a Health Care Practitioner in the Health Care Practitioner's office[, an Acute Medical Facility's Outpatient department,] [a Free-Standing Facility][,] [a Retail Health Clinic] [or] [an Urgent Care Facility]. During this meeting, the Health Care Practitioner

evaluates and manages the Covered Person's Sickness or Injury as defined in the most recent edition of Current Procedural Terminology [or provides preventive medicine services].]
DEF: 400.001.001.GE

- ***DEF: 500.002.GE is replaced with DEF: 500.002.001.GE, which reads as follows:***

[**Pre-Existing Condition**
A Sickness or an Injury and related complications [, not fully disclosed on the [enrollment form]]:

1. For which medical advice, consultation, diagnosis, care or treatment was sought, received or recommended from a provider [or Prescription Drugs were prescribed] during the [24-month] period immediately prior to the Covered Person's Effective Date, regardless of whether the condition was diagnosed, misdiagnosed or not diagnosed; or

2. That produced signs or symptoms during the [24-month] period immediately prior to the Covered Person's Effective Date.

   The signs or symptoms were significant enough to establish manifestation or onset by one of the following tests:

   a. The signs or symptoms reasonably should have allowed or would have allowed one learned in medicine to diagnose the condition; or
   b. The signs or symptoms reasonably should have caused or would have caused an ordinarily prudent person to seek diagnosis or treatment.

   [A pregnancy that exists on the day before the Covered Person's Effective Date will be considered a Pre-Existing Condition.]]
DEF: 500.002.001.GE

- ***PAR: 010.001.GE is replaced with PAR: 010.001.001.GE, which reads as follows:***

[**Methodology Is Subject to Change**
The Maximum Allowable Amount methodologies listed above may be amended or replaced from time to time at Our discretion, without notice. [Our current methodologies can be obtained by calling Our Home Office.]]

[**Using the** [**Health Care Provider Network**] [**Participating Provider Network**]
To receive payment at the desired benefit level, You [and Your Covered Dependents] must meet the requirements for using [Network] [Participating] Providers and must comply with all other plan requirements. [IT IS <u>YOUR</u> RESPONSIBILITY to verify that a provider is participating in the [Health Care Provider Network] [Participating Provider Network] [and whether that provider is participating as a [Participating Provider,] [or] [[Select] Participating Provider] [or] [Designated Specialty Provider]] <u>at the time of service</u>.]]

[**Using Designated Specialty Providers**
If the Covered Person elects to receive designated covered specialty services from a Designated Specialty Provider, benefits may be paid at a higher benefit level than when a [Participating Provider] [or] [[Select] Participating Provider] is used. The benefit level payable when designated specialty treatment, services or

supplies are received from a Designated Specialty Provider is shown in the Benefit Summary. For the Designated Specialty Provider benefit level to be payable, both the service and the provider must be designated by Us at the specialty services benefit level. IT IS YOUR RESPONSIBILITY to verify that a provider is a Designated Specialty Provider at the time of service and that the services to be received are designated as specialty services from that provider.]

[**Using Network Facilities**
Even when the Covered Person receives treatment, services or supplies from a network facility, the care may be administered by [Non-Network] [Non-Participating] Providers. IT IS YOUR RESPONSIBILITY to verify that a provider is a [Network] [Participating] Provider at the time of service.]

[**Receiving Care for Emergency Conditions**
Covered Charges for [Non-Network] [Non-Participating] Provider Emergency Treatment[, Urgent Care] and Emergency Confinement will be paid at the Participating Provider benefit level until the Covered Person's condition has stabilized. After the condition has stabilized, benefits will be paid at the [Non-Network] [Non-Participating] Provider benefit level. We will, if possible, assist in the Covered Person's transfer to a [Network] [Participating] Provider if requested by the Covered Person. [Covered Charges for [Non-Network] [Non-Participating] Provider Emergency Treatment[, Urgent Care] and Emergency Confinement may be subject to Maximum Allowable Amount reductions.]]

[**Receiving Ancillary Services**
Please note that certain ancillary services, such as lab tests or services performed by anesthesiologists, radiologists, pathologists or Emergency Room physicians, that are ordered by a [Network] [Participating] Provider are sometimes out-sourced to a [Non-Network] [Non-Participating] Provider. [Covered Charges for such services will be processed as [Non-Network] [Non-Participating] Provider benefits.] [To obtain [Network] [Participating] Provider benefits, it is important that such services be referred to another [Network] [Participating] Provider when possible.] [[Covered Charges for such services rendered in association with direct treatment from a [Network] [Participating] Provider will be paid at the corresponding benefit level].] [and may be subject to the Maximum Allowable Amounts for [Network] [Participating] Providers and Maximum Allowable Amounts for [[Non-Network] [Non-Participating]] Providers provisions.]] [A higher benefit level may be available if the Covered Person uses a Designated Specialty Provider for ancillary services that are designated by Us to be specialty services from that provider.]]]
PAR: 010.001.001.GE

- ***MED: 065.001.GE is replaced with MED: 065.001.001.GE, which reads as follows:***

[**Outpatient Physical Medicine Services**
[Services provided [in the Outpatient department of an Acute Medical Facility,] [by a licensed therapist,] [or] [by a licensed or certified agency in a Covered Person's home] [or] [on an Outpatient basis] that include, but are not limited to:]

[1.] [Physical Therapy, Occupational Therapy and Speech Therapy.]

[2.] [Pulmonary rehabilitation programs.]

[3.] [Adjustments[, and] manipulations [and] [massage therapy].]

[4.] [Cardiac Rehabilitation Programs.]

[5.] [Services for treatment of Developmental Delay.]

Coverage for Outpatient Physical Medicine services will cease when measurable and significant progress toward expected and reasonable outcomes has been achieved or has plateaued as determined by Us.

For laboratory services and Diagnostic Imaging services benefits, see the Diagnostic Imaging Services and Laboratory Services provision in this section.]
MED: 065.001.001.GE

- ***MED: 075.001.GE is replaced with MED: 075.001.001.GE, which reads as follows:***

[**Durable Medical Equipment and Personal Medical Equipment**
[1.] [Rental or purchase, whichever is most cost effective as determined by Us, of the following items when prescribed by a Health Care Practitioner:]

[a.] [A wheelchair.]
[b.] [A basic Acute Medical Facility bed.]
[c.] [Basic crutches.]

[2.] [Casts, splints, trusses and orthopedic braces, excluding foot orthotics.]

[3.] [The [temporary interim and] initial permanent basic artificial limb or eye.]

[4.] [External breast prostheses needed because of surgical removal of all or part of the breast.]

[5.] [Oxygen and the equipment needed for the administration of oxygen.]

[6.] [Other Durable Medical Equipment and supplies that are approved in advance by Us.]

[Charges for replacement of or maintenance, repair, modification or enhancement to the whole or parts of wheelchairs will be covered when authorized by Us before any equipment is purchased.] [Charges for replacement of or maintenance, repair, modification or enhancement to the whole or parts of any of the items listed above, other than wheelchairs, are not covered, regardless of when the item was originally purchased.] [Replacements due to outgrowing [wheelchairs] [and] [or] Durable [or Personal] Medical Equipment] as a result of the normal skeletal growth of a child will be covered when authorized by Us before any equipment is purchased.] [Charges for duplicate [wheelchairs] [and] [or] Durable Medical Equipment, Personal Medical Equipment and supplies are not covered.]]
MED: 075.001.001.GE

- ***MED: 275.001.GE is added:***

[**Repatriation Services**
Covered Charges are for the preparation and transportation of a Covered Person's remains to his or her home country or [country] [state] of regular domicile should the Covered Person die while covered under this plan[, provided treatment of the Illness or Injury that caused the Covered Person's death would have been covered under this plan had the person not died]. If applicable, such action will be in accordance with any international transportation requirements.

[Repatriation must be authorized by Us in advanced before the remains are prepared for transportation.] [No benefits will be paid for transportation expenses of anyone accompanying the body.]]
MED: 275.001.GE

- ***DEF: 280.001.GE is added:***

[**Medical Evacuation Services**:
Covered Charges are for the Covered Person's Medically Necessary evacuation to his or her home country or to a facility operated pursuant to the laws of his or her home country for the treatment of a Sickness or Injury, should the Covered Person be admitted on an Inpatient basis to [an Acute Behavioral Health Inpatient Facility,] an Acute Medical Facility or other licensed facility as a result of a Sickness or Injury.

[Medical Evacuation must be [authorized by Us in advance before the Covered Person is evacuated] [and] [approved by the attending Health Care Practitioner]. [Except as specifically provided herein, no benefits will be provided for charges Incurred outside of the United States or its possessions [or Canada].]]
MED: 280.001.GE

- ***RXP: 005.002.GE is replaced with RXP: 005.002.001.GE, which reads as follows:***

[[VIII.] [OUTPATIENT PRESCRIPTION DRUG BENEFITS]

[ONLY THE PRESCRIPTION DRUGS LISTED AS OUTPATIENT PRESCRIPTION DRUG BENEFITS IN THIS SECTION OF THE PLAN WILL BE CONSIDERED COVERED CHARGES. HOW COVERED CHARGES ARE PAID AND THE MAXIMUM BENEFIT FOR THE COVERED PRESCRIPTION DRUGS LISTED IN THIS SECTION ARE SHOWN IN THE BENEFIT SUMMARY. REFER TO THE EXCLUSIONS SECTION OF THE PLAN FOR DRUGS, MEDICATIONS AND SUPPLIES THAT ARE NOT COVERED UNDER THIS PLAN.

[THE COVERED PERSON MUST FOLLOW THE UTILIZATION REVIEW PROVISIONS SECTION [AND USE THE PARTICIPATING PHARMACY NETWORK] [OR SPECIALTY PHARMACY NETWORK] TO RECEIVE THE MAXIMUM BENEFITS AVAILABLE UNDER THIS PLAN.]

[PRIOR AUTHORIZATION MAY BE REQUIRED FOR CERTAIN PRESCRIPTION DRUGS BEFORE THEY ARE CONSIDERED FOR COVERAGE UNDER THE OUTPATIENT PRESCRIPTION DRUG BENEFITS SECTION. PLEASE ACCESS THE WEBSITE LISTED ON THE BACK OF THE IDENTIFICATION (ID) CARD TO RECEIVE INFORMATION ON WHICH PRESCRIPTION DRUGS REQUIRE PRIOR AUTHORIZATION, TO CHECK PRESCRIPTION DRUG COVERAGE AND PRICING OR TO LOCATE A PARTICIPATING PHARMACY.]]

[After the Covered Person has paid any [Ancillary Charge,] [Ancillary Pharmacy Network Charge,] [Coinsurance,] [Copayment,] [Deductible] or any other applicable fees, benefits will be paid by Us for Covered Charges for Outpatient Prescription Drugs listed in this section of the plan. Any applicable [Coinsurance,] [Copayment,] [Deductible] or other fees [and the Prescription Drug Class] [and] [time period] [Plan Year] [Calendar Year] [Benefit Period] [to which they apply] are shown in the Benefit Summary. Benefits paid under this section will be applied to the Maximum Lifetime Benefit and are also subject to any other maximum benefit for Prescription Drugs provided under this plan. Benefits are subject to all the terms, limits and conditions in this plan.]

[Any [Ancillary Charge] [or] [any Ancillary Pharmacy Network Charge] under this section will not count toward satisfying any [Access Fee,] [Coinsurance,] [Copayment,] [Deductible] [or] [Out-of-Pocket Limit] under the medical section or any other section in this plan.]

[After the Covered Person has paid any [Ancillary Charge,] [and] [or] [Ancillary Pharmacy Network Charge,] [and] [or] [Prescription Drug Coinsurance,] [and] [or] [Prescription Drug Copayment,] [and] [or] [Prescription Drug Deductible] or any other applicable fees, benefits will be paid by Us for Covered Charges for Outpatient Prescription Drugs listed in this section of the plan.] [Any applicable [Prescription Drug Coinsurance,] [and] [or] [Prescription Drug Copayment,] [and] [or] [Prescription Drug Deductible] or other fees [and the Prescription Drug Class] [and] [time period] [Plan Year] [Calendar Year] [Benefit Period] [to which they apply] are shown in the Benefit Summary.] [Benefits paid under this section will be applied to the Maximum Lifetime Benefit and are also subject to any other maximum benefit for Prescription Drugs provided under this plan. Benefits are subject to all the terms, limits and conditions in this plan.]]

[Any [Ancillary Charge,] [and] [or] [Ancillary Pharmacy Network Charge,] [and] [or] [Prescription Drug Coinsurance,] [and] [or] [Prescription Drug Copayment,] [and] [or] [Prescription Drug Deductible,] under this section will not count toward satisfying any [Access Fee,] [and] [or] [Coinsurance,] [and] [or] [Copayment,] [and] [or] [Deductible] [and] [or] [Out-of-Pocket Limit] under the medical section or any other section in this plan.]

[Unless a Prescription Drug is specifically listed as a Covered Charge in the Medical Benefits section, all Prescription Drugs that are received on an Outpatient basis are considered for benefits under the Outpatient Prescription Drug Benefits section.] [Any amount in excess of the maximum amount provided under this section is not covered under any other section of this plan.] [Expenses Incurred under this section do [not] apply toward any Out-of-Pocket Limits under any other section of this plan.]

[A Prescription Drug must be dispensed through a [Participating Pharmacy] [or Specialty Pharmacy Provider] to receive benefits.] [Prescription Maintenance Drugs must be dispensed through a Mail Service Prescription Drug Vendor to receive benefits.] [Certain Prescription Drugs may be covered under this plan only if they are dispensed through a Specialty Pharmacy Provider.] [These limitations will be shown in the Benefit Summary.]

[This plan provides benefits only for the following Covered Charges for [Prescription] [Generic] Drugs that are received on an Outpatient basis [and dispensed through a] [Participating Pharmacy] [or Specialty Pharmacy Provider] [as shown in the Benefit Summary]:

[1.] [[Prescription] [Generic] Drugs that are fully approved by the U.S. Food and Drug Administration (FDA) for marketing in the United States and can be obtained only with a Prescription Order from a Health Care Practitioner.]

[2.] [[Prescription] [Generic] Drugs that are listed in Our Drug List.]

[3.] [[Up to a] [15 consecutive day] supply for each Prescription Order, unless restricted to a lesser amount by the Prescription Order, the manufacturers' packaging or any limitations in this plan. [If a Mail Service Prescription Drug Vendor is used, We will pay [up to a] [90 consecutive day] supply for each Prescription Order for Prescription Maintenance Drugs covered by and through the Mail Service

Prescription Drug Vendor, unless restricted to a lesser amount by the Prescription Order, the manufacturer's packaging, additional dispensing limitations or other limitations in this plan.]]

[4.] [[Up to] [3 vials] [or] [up to a] [15 consecutive day] supply of one type of self-injectable insulin for each Prescription Order[, whichever is less]. [If a Mail Service Prescription Drug Vendor is used, We will pay [up to] [9 vials] [or] [up to a] [90 consecutive day] supply of one type of self-injectable insulin for each Prescription Order[, whichever is less].]]

[5.] [[Up to] [100] disposable insulin syringes and needles[, up to] [100] disposable blood/urine/glucose/acetone testing agents[, or] [up to] [100] lancets[, or] [up to a] [15 consecutive day] supply for each Prescription Order[, whichever is less]. [If a Mail Service Prescription Drug Vendor is used, We will pay [up to] [300] disposable insulin syringes and needles [or] [up to] [300] disposable blood/urine/glucose/acetone testing agents [or] [up to] [300] lancets[, or] [up to a] [90 consecutive day] supply for each Prescription Order[, whichever is less].]]

[6.] [Prescription Maintenance Drugs that are dispensed through a Mail Service Prescription Drug Vendor. We will pay for the following:

[a.] [Up to] [9 vials] [or] [up to a] [90 consecutive day] supply of one type of self-injectable insulin for each Prescription Order[, whichever is less].]
[b.] [Up to] [300] disposable insulin syringes and needles [or] [up to] [300] disposable blood/urine/glucose/acetone testing agents [or] [up to] [300] lancets[, or] [up to a] [90 consecutive day] supply for each Prescription Order[, whichever is less].]
[c.] [Up to a] [90 consecutive day] supply for each Prescription Order for Prescription Maintenance Drugs, unless restricted to a lesser amount by the Prescription Order, the manufacturer's packaging, additional dispensing limitations or other limitations in this plan.]]

[7.] [[Prescription] [Generic] Drugs, in dosages, dosage forms, dosage regimens and durations of treatment that are Medically Necessary for the treatment of a Sickness or an Injury that is covered under this plan.]

[8.] [[Prescription] [Generic] Drugs that are within the quantity, supply, cost-sharing or other limits that We determine are appropriate for a [Prescription] [Generic] Drug [or within a Therapeutic Class based on the Prescription Drug Class].]

[9.] [[Prescription] [Generic] Drugs and [Prescription] [Generic] Drug products if all active ingredients are covered under this plan.]

[10.] [[Prescription] [Generic] Drugs used for Outpatient treatment of [Behavioral Health] [or] [Substance Abuse].]

[11.] [[Prescription] [Generic] Drugs used for contraception that are oral contraceptives, contraceptive patches, contraceptive vaginal rings or diaphragms. Injectable contraceptives and contraceptive implants are not covered.]

[12.] [Specialty Pharmaceuticals that are authorized by Us to be paid under the Outpatient Prescription Drug Benefits section [and are obtained through a [Participating Pharmacy] [or] [Specialty Pharmacy Provider].]

[**Manufacturer's Packaging Limits**
Some Prescription Drugs [or Therapeutic Classes of drugs] may be subject to additional supply, quantity, duration, gender, age, lifetime, cost sharing or other limits based on the manufacturer's packaging, plan limits or the Prescription Order. Examples of these situations are:

[1.] [If a Prescription Drug is taken on an as-needed basis, only enough medication for a single episode of care may be covered per Prescription Drug Copayment][; or]

[2.] [If two or more covered Prescription Drug products are packaged and/or manufactured together, the Covered Person may be required to pay a Prescription Drug Copayment and Prescription Drug Coinsurance amount for each of the Prescription Drug products contained in the packaging and/or in the combination Prescription Drug product][; or]

[3.] [If two or more Prescription Drug products are packaged and/or manufactured together and one or more of the active ingredients in the products are not covered, then the entire packaged and/or manufactured combination product is not covered under this plan].]

[Any Prescription Drug which is a metabolite, isomer, extended release or other dosage form, unique salt or other formulation, or other direct or indirect derivative of a Prescription Drug approved by the FDA may be subject to similar terms, limits and conditions of coverage or will not be covered by this plan if the original drug would not be covered.]]

PAYMENT OF BENEFITS

[**Participating Pharmacy**
Present the identification (ID) card to the Participating Pharmacy to obtain benefits. The Covered Person must pay any applicable [Coinsurance] [and] [Deductibles] [under the Medical Benefits section,] [Ancillary Charge,] [Prescription Drug] [Coinsurance,] [Prescription Drug] [Copayment] [and] [or] [Prescription Drug] [Deductible] to the Participating Pharmacy. The following additional cost sharing provisions apply to covered Outpatient Prescription Drugs purchased at a Participating Pharmacy when the ID card is used to obtain benefits:

[1.] [When a covered Generic Drug is available and that Generic Drug is received, the Covered Person pays the [Prescription Drug Copayment] [and] [or] [Contracted Rate] for that Generic Drug as shown in the [Benefit Summary] [Drug List].]

[2.] [When a Generic Drug is not available and a Brand Name Drug is received, the Covered Person pays the [Prescription Drug Copayment] [and] [or] [Prescription Drug Coinsurance] [and] [or] [Contracted Rate] for that Brand Name Drug as shown in the [Benefit Summary] [Drug List].]

[3.] [If a Brand Name Drug is received when a Generic Drug is available, the Covered Person pays the [Prescription Drug Copayment] [and] [or] [Prescription Drug Coinsurance] [and] [or] [Contracted Rate] for that Brand Name Drug, as shown in the [Benefit Summary] [Drug List], plus the difference in the Contracted Rate between the cost of the Brand Name Drug and the Generic Drug. The difference in the Contracted Rate between the two drugs will not be reimbursed by Us nor does it count toward satisfying any Coinsurance, Deductible or other Out-of-Pocket Limit under the Outpatient Prescription Drug Benefits section [or the Medical Benefits section].]

[4.] [When a covered Prescription Drug is available under two or more names, dosages, dosage forms, dosage regimens or manufacturers' packaging [or when more than one covered Prescription Drug may be used to treat a condition that would be covered under this plan,] We will consider benefits only for the most cost effective drug, dosage form or packaging that would be a Covered Charge under this plan and that will produce a professionally adequate result.]

If the Covered Person does not use the ID card to obtain Prescription Drugs at a Participating Pharmacy, the Covered Person must pay for the Prescription Drugs in full at the Participating Pharmacy. To receive reimbursement for Covered Charges, the Covered Person must file a claim with Us as explained in the How To File A Claim provision in this section. [The Covered Person will be reimbursed at the Contracted Rate that would have been paid to a Participating Pharmacy for the cost of the covered Prescription Drug minus any applicable Ancillary Charge, Ancillary Pharmacy Network Charge, Coinsurance amount, Prescription Drug Copayment and/or Prescription Drug Deductible.] [The Covered Person will be reimbursed up to the Allowance for the cost of the covered Prescription Drug.] [Any Ancillary Charge, Ancillary Pharmacy Network Charge, Coinsurance amount, Prescription Drug Copayment, Prescription Drug Deductible and/or any amounts not paid by Us due to the difference between the billed amount for the Prescription Drug and Our benefit payment do not count toward satisfying any [Access Fee,] [Coinsurance,] [Copayment,] [Deductible] [or] [Out-of-Pocket Limit] under the medical portion [or the Outpatient Prescription Drug Benefits section] of this plan.]]

[**Specialty Pharmacy Provider**
A Covered Person must obtain authorization from Us before a Specialty Pharmaceutical is considered for possible coverage[, as outlined in the Utilization Review Provisions section]. If the Specialty Pharmaceutical is authorized, We will advise the Covered Person how the Specialty Pharmaceutical can be obtained from a Specialty Pharmacy Provider and how to file a claim with Us.]

[**Non-Participating Pharmacy**
When the Covered Person has prescriptions filled at a Non-Participating Pharmacy, the Covered Person must pay for the Prescription Drug in full at the Non-Participating Pharmacy. To receive reimbursement for Covered Charges, the Covered Person must file a claim with Us as explained in the How To File A Claim provision in this section. [The Covered Person will be reimbursed at the Contracted Rate that would have been paid to a Participating Pharmacy [or Specialty Pharmacy Provider] for the cost of the covered Prescription Drug minus any applicable Ancillary Charge, Ancillary Pharmacy Network Charge, Prescription Drug Coinsurance, Prescription Drug Copayment and/or Prescription Drug Deductible.] [The Covered Person will be reimbursed up to the Allowance amount for the cost of the covered Prescription Drug.] [Any Ancillary Charge, Prescription Drug Coinsurance, Prescription Drug Copayment, Prescription Drug Deductible and/or any amounts not paid by Us due to the difference between the billed amount for the Prescription Drug and Our benefit payment do not count toward satisfying any [Access Fee,] [Coinsurance,] [Copayment,] [Deductible] [or] [Out-of-Pocket Limit] under the medical portion of this plan.]]
RXP: 005.002.001.GE

- ***EXC: 110.001.GE is replaced with EXC: 110.001.001.GE, which reads as follows:***

[21.] [Charges for:

[a.] [A private duty nurse; a private duty professional skilled nursing service; a masseur, masseuse or massage therapist; a rolfer; a home health aide or personnel with similar training and

experience; a stand-by Health Care Practitioner][, except as otherwise covered in the Outpatient Physical Medicine Services provision in the Medical Benefits section].]

[b.] [Home Health Care.]
[c.] [Treatment or services provided by a chiropractor.]
[d.] [Custodial Care; [respite care; rest care; supportive care;] homemaker services.]
[e.] [A Health Care Practitioner who is not properly licensed or authorized in the state where services are rendered.]
[f.] [[Phone consultations;] [internet consultations;] [e-mail consultations;] [Telemedicine Services;] [Telehealth Services].]
[g.] [Health Care Practitioner administrative expenses including, but not limited to, expenses for claim filing, contacting utilization review organizations or case management fees.]
[h.] [Missed appointments.]
[i.] [Sales tax; gross receipt tax.]
[j.] [Living expenses; travel; transportation[, except as otherwise covered in the [Professional Ground [or Air] Ambulance Services provision,] [Medical Evacuation Services provision,] [Repatriation Services provision] [or] [Transplants provision] in the Medical Benefits section].]
[k.] [Treatment or services that are furnished primarily for the personal comfort or convenience of the Covered Person, Covered Person's family, a Health Care Practitioner or provider.]]

EXC: 110.001.001.GE

- ***EXC: 175.001.GE is replaced with EXC: 175.001.001.GE, which reads as follows:***

[34.] [Charges for:

[a.] [Non-medical items, self-care or self-help programs.]
[b.] [Aroma therapy.]
[c.] [Meditation or relaxation therapy.]
[d.] [Naturopathic medicine.]
[e.] [Treatment of hyperhidrosis (excessive sweating).]
[f.] [Acupuncture; biofeedback; [neurotherapy;] electrical stimulation; or Aversion Therapy.]
[g.] [Inpatient treatment of chronic pain disorders.]
[h.] [Family or marriage counseling.]
[i.] [Applied behavior therapy treatment for autistic spectrum disorders.]
[j.] [Smoking cessation.]
[k.] [Snoring.]
[l.] [The treatment or prevention of hair loss.]
[m.] [Change in skin pigmentation.]
[n.] [Stress management.]]

EXC: 175.001.001.GE

- ***EXC: 240.001.GE is replaced with EXC: 240.001.001.GE, which reads as follows:***

[47.] [Charges for drugs obtained from pharmacy provider sources outside the United States, except as otherwise covered in the [International Coverage,] [Travel Benefit,] [or] [World Wide Coverage] provision[s] in the Medical Benefits section.]

EXC: 240.001.001.GE

- ***EXC: 300.001.GE is replaced with EXC: 300.001.001.GE, which reads as follows:***

[59.] [Charges for treatment or services required due to Injury received while engaging in any hazardous occupation or other activity for which compensation is received including[, but not limited to,] the following: [Participating,] [or] [instructing,] [or] [demonstrating,] [or] [guiding] [or] [accompanying others] in [parachute jumping,] [or] [hang-gliding,] [or] [bungee jumping,] [or] [racing any [motorized] [or non-motorized] vehicle,] [skiing] [or] [horse riding] [or] [rodeo activities]. Also excluded are treatment and services required due to Injury received while practicing, exercising, undergoing conditioning or physical preparation for any such compensated activity[, unless otherwise noted as a Covered Charge in this plan].]]

EXC: 300.001.001.GE

- ***PRE: 030.001.GE is replaced with PRE: 030.001.001.GE, which reads as follows:***

[**Reinstatement**

If any premium is not paid within the required time period, coverage for You [and any Covered Dependents] will lapse. The coverage will be reinstated if all of the following requirements are met:

[1.] [The lapse was not more than [30 days].]

[2.] [You submit a [supplemental] enrollment form for reinstatement to Us along with the required premium payment. Submission of premium to Your agent is not submission of premium to Us.]

[3.] [We approve Your [supplemental] enrollment form for reinstatement.]

The coverage will be reinstated on the date We approve Your enrollment form for reinstatement. [If We have not responded to Your enrollment form for reinstatement by the 45th day after We receive the enrollment form, the coverage will be reinstated on that date.]

[If the coverage is reinstated, loss resulting from an [Injury] [or] [Sickness] will be covered only if the [Injury] [or] [Sickness] is sustained on or after the date of reinstatement.] [Loss due to a Sickness will be covered only if the Sickness begins [more than] [10 days] after the date of reinstatement.] No benefits will be paid for such condition and related complications if during the time between the lapse date and the reinstatement date:

[1.] [Medical advice, consultation, diagnosis, care or treatment was sought, received or recommended from a provider [or Prescription Drugs were prescribed] regardless of whether the condition was diagnosed or not diagnosed; or]

[2.] [The condition produced signs or symptoms.]

[The signs or symptoms were significant enough to establish manifestation or onset by one of the following tests:

[a.] [The signs or symptoms reasonably should have allowed or would have allowed one learned in medicine to diagnose the condition; or]

[b.] [The signs or symptoms reasonably should have caused or would have caused an ordinarily prudent person to seek diagnosis or treatment.]

This limitation will apply until coverage has been in force for [12 months] after the reinstatement date, unless the condition has been specifically excluded from coverage.

In addition, death occurring between the lapse date and the reinstatement date will not be covered under the Life Insurance Benefits section.

In all other respects, You and Our Company will have the same rights as existed under this plan before the coverage lapsed[, subject to any provisions included with or attached to this plan in connection with the reinstatement].]]
PRE: 030.001.001.GE

- ***OTH: 041.001.GE is added:***

[**Deductible Credit Program**
[[Beginning the earlier of the [January 1st –December 31st] [or] [January 1st –December 31st] that next follows the [[30th-365th] [day] [[0-12] [months] after Your Effective Date, You will receive a [5%-20%][$XXX] credit to Your [Individual] [Family] [Integrated] [and] [Network] [Participating][,][and] [Non-Network] [Non-Participating] Deductible for each [[0-12]-month] period during which the Deductible less any accumulated credits has gone unsatisfied.] [Each [5%-20%][$XXX] credit will be based on Your [Individual] [Family] [Integrated] [and] [Network] [Participating][,][and] [Non-Network] [Non-Participating] Deductible [less any accumulated credits].] [At no time will Your [Individual] [Family] [Integrated] [and] [Network] [Participating][,][and] [Non-Network] [Non-Participating] Deductible less any accumulated credits be less than [$XXX].]]

[When Covered Charges equal to the [Individual][or] [Family][or] [Integrated] [and] [Network] [Participating][,][and] [Non-Network] [Non-Participating] Deductible less any accumulated credits have been Incurred and processed by Us, the [Individual][or] [Family][or] [Integrated] [and] [Network] [Participating][,][and] [Non-Network] [Non-Participating] Deductible will be satisfied for the remainder of that Calendar Year.] [On January 1st of the following Calendar Year, You will return to the [Individual][or] [Family][or] [Integrated] [and] [Network] [Participating][,][and] [Non-Network] [Non-Participating] Deductible amount, as shown on Your Benefit Summary.]]]

[This Deductible Credit Program may be discontinued at any time by providing You with a prior [30-180]-day notice.]]
OTH: 041.001.GE

- ***OTH: 041.002.GE is added:***

[**Deductible Reward Program**
[[You will receive a [one-time] [5%-25%][$XXX] Deductible [credit] [reward] [monthly] [quarterly] [semi-annually] [annually] [at renewal] to Your [Individual][or] [Family][or] [Integrated] [and] [Network] [Participating][,][and] [Non-Network] [Non-Participating] Deductible [if [during a [[6-24]-month] period]] Your [Individual][or] [Family][or] [Integrated] [and] [Network] [Participating][,][and] [Non-Network] [Non-Participating] Deductible has not been satisfied].] [At no time will Your [Individual][or] [Family][or] [Integrated] [and] [Network] [Participating][,][and] [Non-Network] [Non-Participating] Deductible less any accumulated [credits] [reward] be less than [$XXX][or the minimum HSA-Qualified deductible amount for HSA-Qualified plans].]]

[This Deductible Reward Program may be discontinued at any time by providing You with a prior [30-180]-day notice.]]
OTH: 041.002.GE

- ***OTH: 041.003.GE is added:***

[**Multi Year Deductible**
[[You will receive a [one-time] [5%-25%][$XXX] Deductible [credit] [reward] [monthly] [quarterly] [semi-annually] [annually] [at renewal] to Your [Individual][or] [Family][or] [Integrated] [and] [Network] [Participating][,][and] [Non-Network] [Non-Participating] Deductible [for a [18-60][-month period] [for the period shown on the benefit summary] [if [during a [[6-24]-month] period]] Your [Individual][or] [Family][or] [Integrated] [and] [Network] [Participating][,][and] [Non-Network] [Non-Participating] Deductible has not been satisfied].] [At no time will Your [Individual][or] [Family][or] [Integrated] [and] [Network] [Participating][,][and] [Non-Network] [Non-Participating] Deductible less any accumulated [credits] [reward] be less than [$XXX][or the minimum HSA-Qualified deductible amount for HSA-Qualified plans].]]

[This Multi Year Deductible Program may be discontinued at any time by providing You with a prior [30-180]-day notice.]]
OTH: 041.003.GE

Secretary

TIME INSURANCE COMPANY
501 West Michigan
Milwaukee, WI 53203

CONDITION SPECIFIC DEDUCTIBLE ENDORSEMENT

[NOTICE: ALL COPIES MUST BE SIGNED --- RETURN ONE COPY TO THE HOME OFFICE]
This endorsement is attached to and made part of [Policy/Certificate] No.
[0000123456]
This endorsement applies to
[Jane Doe]
Effective Date
[January 1, 1111]

[This is a permanent endorsement.] [Removal of this endorsement is automatic. It will be removed on [January 1, 1111].] [Removal of this endorsement is not automatic, but will be considered upon request after [January 1, 1111].]

The provisions of this endorsement supersede any provisions of the [Policy/Certificate] or any attached rider with which they may conflict.

Covered Charges for Covered Medical Services [and for Covered Prescription Drug Services] incurred in whole or in part because of, or any complications related to, or the underlying causes of

[Insert medical condition]

are subject to a separate deductible in the amount of $[XXXX] each calendar year. These Covered Charges shall first be applied to satisfy this deductible and shall thereafter apply as appropriate to any other Deductible, term or condition of the [Policy/Certificate].

This endorsement does not vary, alter waive or extend any of the terms, conditions, agreements or limitations of the [Policy/Certificate] other than as above stated.

John Emmerson

Secretary

[Accepted at:

_____
City or Town State

_____ _____]
Insured Sign Here Date
(If minor, legal guardian signature)

TIME INSURANCE COMPANY
501 West Michigan
Milwaukee, WI 53203

[NOTICE: ALL COPIES MUST BE SIGNED --- RETURN ONE COPY TO THE HOME OFFICE]

[This is a permanent rider.] [Removal of this rider is automatic. It will be removed on [January 1, 1111].] [Removal of this rider is not automatic, but will be considered upon request after [January 1, 1111].]

******ATTACH THIS SPECIAL EXCEPTION RIDER TO YOUR [POLICY/CERTIFICATE] ******

Special Exception Rider

It is hereby understood and agreed that the [Policy/Certificate] to which this rider is attached is amended to provide that the [Policy/Certificate] does not cover anything of which:

[Insert rider verbiage here]

of [John Doe], [Primary Insured/Spouse/Dependent], is the sole, contributory, primary, or secondary cause, anything in the [Policy/Certificate] to the contrary notwithstanding.

Nothing herein contained shall be held to vary, alter, waive or extend any of the terms, conditions, agreements or limitations of the Coverage other than as above stated.

Attached to and hereby made a part of [Policy/Certificate] No. [0000123456] issued to [John Doe], this [01] day of [January], [1111].

Secretary

[Accepted at:

_____
City or Town State

_____ _____]
Insured Sign Here Date
(If minor, legal guardian signature)

BENEFIT SUMMARY

[POLICYHOLDER INFORMATION]

[**POLICYHOLDER**]	[**ABC Trust/Association**]
[**LOCATION**]	[**City/State**]

[CERTIFICATE HOLDER] INFORMATION

[**CERTIFICATE HOLDER**] [Dependents]	[John Doe] [Jane Doe] [Mary Doe] [James Doe]
[**CERTIFICATE NUMBER**]	[0000001]
[**EFFECTIVE DATE**] [of this schedule]	[00/00/0000]
[**PLAN ID**] [**PLAN TYPE**]	[Plan name inserted here – CoreMed, MaxPlan, etc.]
[**PARTICIPATING EMPLOYER**]	[ABC Company]
[**GROUP NUMBER**]	[1900AK0000]
[**LOCATION NUMBER**]	[001]
[**BENEFIT PERIOD**]	[35 days]
[**BENEFIT PERIOD TERMINATION DATE**]	[05/05/2006]
[**PAYMENT OPTION**]	[Single Payment][Monthly Payment]
[[**BENEFIT**] **WAITING PERIOD**]	[3 days from Effective Date for Sickness]

This Summary contains limited information about Your plan. PLEASE READ YOUR CERTIFICATE CAREFULLY TO UNDERSTAND YOUR COVERAGE.

The Utilization Review Provisions [and the [Select Participating Provider Network] [Select Network] [Participating Provider Network] [Network Provider] [Network]] must be utilized, to be eligible to receive the maximum benefits available under the policy. Refer to the Utilization Review Provisions for the medical benefits that must be reviewed.

Major Medical Benefits for [Single Plan/Family Plan] [Certificate Holder-Spouse Plan] [Certificate Holder-Children Plan].

[The [Select Participating Provider Network] [Select Network] [Participating Provider Network] [Network Provider is [PPO].]

Benefits will be paid for Covered Charges Incurred while coverage is in force. Payment of benefits will be subject to all benefit provisions and other conditions of the plan. The benefits listed in this schedule are for each Covered Person unless otherwise indicated.

[[**BENEFIT PERIOD**] [**MAXIMUM** [**LIFETIME**] **BENEFIT**]] [for each [Covered Person] [Family] [Accident] [Injury] [Sickness]]	[$100,000 - $100,000,000]
[**CALENDAR YEAR MAXIMUM BENEFIT**] [for each [Covered Person] [Family] [Accident] [Injury] [Sickness]]	[$25,000 - $500,000]
[[**ACCIDENT**] [**SICKNESS**] **MAXIMUM BENEFIT**] [for each [Covered Person] [Family] [Accident] [Injury] [Sickness]]	[$500 - $5,000]

[**DAILY MAXIMUM BENEFIT**] [for each [Covered Person] [Family] [Accident] [Injury] [Sickness]]	[$100 - $10,000]
[**PLAN YEAR MAXIMUM BENEFIT**] [for each [Covered Person] [Family] [Accident] [Injury] [Sickness]]	[$25,000 - $500,000]
[**PER CAUSE MAXIMUM BENEFIT**] [for each [Covered Person] [Family]]	[$1,000 - $200,000]
[**OUTPATIENT** [**CALENDAR YEAR**] [**PLAN YEAR**] [**BENEFIT PERIOD**] [**TIME PERIOD**] **MAXIMUM BENEFIT**] [for each [Covered Person] [Family]]	[$1,000 - $50,000]
[**MONTHLY MAXIMUM BENEFIT**] [for each [Covered Person] [Family]]	[$1.000 - $50,000]

BEN: 005.001.001.GE

PLAN DEDUCTIBLES

[[Annual]Carryover Deductible]
Covered Charges Incurred by a Covered Person [due to an Accident] [for Inpatient services] [for Inpatient services received on December 31st of a Calendar Year] [during the last [3] months of a [Plan Year] [Calendar Year] [Benefit Period]] that count toward satisfying a Covered Person's [Individual Deductible,] [Integrated Deductible] [or] [Non-Participating][Non-Network] Provider Deductible,] [but do not satisfy the [Network] [Participating] Provider Deductible] [Individual Out-of-Pocket Limit] for that [Plan Year,] [Calendar Year,] [Benefit Period,] will also count toward satisfying the Covered Person's [Individual Deductible] [or] [Non-Participating][Non-Network] Provider Deductible] for the next [Plan Year] [Calendar Year] [Benefit Period]. [This Carryover Deductible [does not count toward satisfying the [maximum] Family Deductible] [and] [only applies in the first [Plan Year] [Calendar Year] [Benefit Period].] [For the purpose of determining whether a Carryover Deductible applies, Covered Charges will be considered to apply toward the [Individual Deductible] [or] [Non-Participating][Non-Network] Provider Deductible] in the order the Covered Charges are processed.]]

[The [Select Network,] [Network] and [[Non-Network] [Non-Participating Provider]] Deductibles are calculated separately.] [[For example,] Amounts applied toward Your [Select Network] Deductible will not be credited toward Your [Network] Deductible, and amounts credited toward Your [[Non-Network] [Non-Participating Provider]] Deductible will not be credited toward Your [Network] Deductible.]

[All Deductibles are calculated separately. Applicable Deductibles must be satisfied prior to any payment of Covered Charges.]

[Deductibles may apply to specific types of services. Please review the Benefit Summary for additional Deductible information.]

	[[Select] Participating Provider Benefits / [Select] Network]	**[Participating Provider Benefits / Network Provider Benefits]**	**[Non-[Select] Participating Provider Benefits/Non-Participating Provider Benefits/ Non-Network Provider Benefits]**
Individual Plan Deductible [*] [each] [every] [XX] [Calendar Year[s]] [Benefit Period[s]] [Per Cause] [Time Period[s]] [Plan Year[s]]	[None / $0 - $30,000]	[None / $0 - $30,000]	[$0 - $30,000]
[[Maximum] [Family] Plan [Integrated] [Per Cause] Deductible][*] [each] [every [XX]] [Calendar Year[s]] [Benefit Period[s]] [Per Cause] [Time Period[s]] [Plan Year[s]]	[None / $0 - $30,000]	[None / $0 - $30,000]	[None / $0 - $30,000]
[[Maximum] [Common][Accident] [Per Cause] Deductible][*] [each] [every [XX]] [Calendar Year[s]] [Benefit Period[s]] [Per Cause] [Time	[None / $0 - $30,000]	[None / $0 - $30,000]	[None / $0 - $30,000]

Period[s]] [Plan Year[s]]			
[Non-Participating] [Non-Network] Provider Deductible is in addition to the [Participating] [Network] Provider Deductible.]			
[Once [[2] or more Covered Persons have collectively met] the maximum Family Deductible [has been met], no additional Deductible will be taken during the [XX] [Calendar Year[s]] [Plan Year[s]] [Benefit Period[s]] [Time Period[s]].]			

[* We may adjust this amount periodically to ensure that it is not less than the [minimum] [maximum] amount permitted by federal law.]
BEN: 010.001.001.GE

[[**Deductible**] [**Credit**] [**Reward**] [**Multi Year Deductible**] **Program**:]
[[**DEDUCTIBLE**] [**CREDIT**] [**REWARD**] [**MULTI YEAR DEDUCTIBLE**] **PROGRAM EFFECTIVE DATE**] [00/00/0000]
[[**DEDUCTIBLE**] [**CREDIT**] [**REWARD**] [**MULTI YEAR DEDUCTIBLE**] **PROGRAM TERMINATION DATE**] [00/00/0000]
[[Amounts may be credited to Your Deductibles based on the [Deductible] [Credit] [and] [or] [Reward] [and] [or] [Multi Year Deductible] Program.] [At no time will Your [Individual] [Family] [Integrated] [and] [Network] [Participating][,][and] [Non-Network] [Non-Participating] Deductible less any accumulated [credits] [and] [or] [reward] [and] [or] [Multi Year Deductible] be less than [$XXX][or the minimum HSA-Qualified deductible amount for HSA-Qualified plans].]]

BEN: 010.002.GE

[**Plan**] **Coinsurance**] [**and**] [[**Total**] [**Plan**] **Out-of-Pocket Limits**] [The Coinsurance is listed below unless specified elsewhere in the Benefit Summary]			
[Once the [Total] Out-of-Pocket limit is met the plan pays at [100%][unless otherwise specified]]			
[The Out-of-Pocket maximums for [Select Participating Providers,] [Select Network,] [Participating Providers,] [Network Provider] [and] [[Non-Participating] [Non-Network] Providers] are calculated separately. [For example,] Amounts credited toward Your [Participating][Network] Provider Out-of-Pocket maximum will [not] be credited toward Your Non-Participating Provider[Non-Network] Out-of-Pocket maximum, and amounts credited toward Your [Non-Participating] [Non-Network] Provider Out-of-Pocket maximum will [not] be credited toward Your [Participating] [Network] Provider Out-of-Pocket maximum.]			
[All Out-of-Pocket Limits are calculated separately. Applicable Out-of-Pocket Limits must be satisfied prior to any payment of Covered Charges. [Out-of-Pocket Limits do not include Deductible.]			
[[Coinsurance] [and] [Out-of--Pocket Limits] may apply to specific types of services. Please review the Benefit Summary for additional [Coinsurance] [and] [Out-of--Pocket Limits] information.]			
[Any applicable Prescription Drug Deductible, Coinsurance, Copayment [or Ancillary Charge] are calculated separately from the Plan Out-of-Pocket and do not count toward the plan Out-of-Pocket.]			
	[[Select] Participating Provider [Benefits]/ [Select] Network]]	**[Participating Provider [Benefits] / Network Provider [Benefits]]**	**[Non-[Select] Participating Provider [Benefits]/ Non-Participating Provider [Benefits]/ Non-Network Provider [Benefits]]**
[Tier [1]] [*] [Plan] [Coinsurance]	[[0% - 100%] [until the [Plan] [Tier [1]] Out-of-Pocket Limits are satisfied; [then Tier [2];] [100% thereafter.]]	[[0% - 100%] [until the [Plan] [Tier [1]] Out-of-Pocket Limits are satisfied; [then Tier [2];] [100% thereafter.]]	[[0% - 100%] [until the [Plan] [Tier [1]] Out-of-Pocket Limits are satisfied; [then Tier [2];] [100% thereafter.]]
[Tier [1]][*] [Out-of-Pocket Limit] [each [Calendar Year] [Benefit Period] [Time Period] [Plan Year] [Individual][*]	[$0 - $50,000 / Not applicable]	[$0 - $50,000 / Not applicable]	[$0 - $50,000 / an additional $0 - $10,000]

[Family][*]	[$0 - $150,000 / Not applicable]	[$0 - $150,000 / Not applicable]	[$0 - $150,000 / an additional $0 - $30,000]
[Tier [2]][*] [Plan] [Coinsurance]	[[0% - 100%] [until the [Plan] [Tier [2]] Out-of-Pocket Limits are satisfied; [then Tier [X];] [100% thereafter.]]	[[0% - 100%] [until the [Plan] [Tier [2]] Out-of-of-Pocket Limits are satisfied; [then Tier [X];] [100% thereafter.]]	[[0% - 100%] [until the [Plan] [Tier [2]] Out-of-Pocket Limits are satisfied; [then Tier [X];] [100% thereafter.]]
[Tier [2]][*] [Out-of-Pocket Limit] [each [Calendar Year] [Benefit Period] [Time Period] [Plan Year] [Individual][*]	[$0 - $50,000 / Not applicable]	[$0 - $50,000 / Not applicable]	[$0 - $50,000 / an additional $0 - $10,000]
[Family][*]	[$0 - $150,000 / Not applicable]	[$0 - $150,000 / Not applicable]	[$0 - $150,000 / an additional $0 - $30,000]
[Tier [X]][*] [Plan][Coinsurance]	[[0% - 100%] [until the [Plan] [Tier [X]] Out-of-Pocket Limits are satisfied; [then Tier [X + [1];] [100% thereafter.]]	[[0% - 100%] [until the [Plan] [Tier [X]] Out-of-of-Pocket Limits are satisfied; [then Tier [X + [1];] [100% thereafter.]]	[[0% - 100%] [until the [Plan] [Tier X]] Out-of-Pocket Limits are satisfied; [then Tier [X + [1];] [100% thereafter.]]
[Tier [X]][*] [Out-of-Pocket Limit] [each [Calendar Year] [Benefit Period] [Time Period] [Plan Year] [Individual][*]	[$0 - $25,000 / Not applicable]	[$0 - $25,000 / Not applicable]	[$0 - $25,000 / an additional $0 - $10,000]
[Family][*]	[$0 - $75,000 / Not applicable]	[$0 - $75,000 / Not applicable]	[$0 - $75,000 / an additional $0 - $30,000]
[Total] [Plan] [Out-of-Pocket (OOP) Limits][*]			
[Individual Out-of-Pocket Limit each [Calendar Year] [Plan Year][Benefit Period][*]	[$0 - $25,000 / Not applicable]	[$0 - $25,000 / Not applicable]	[$0 - $25,000 / an additional $0 - $10,000]
[Common] [Family Out-of-Pocket Limit each [Calendar Year] [Plan Year][Benefit Period][*]	[$0 - $75,000 / Not applicable]	[$0 - $75,000 / Not applicable]	[$0 - $75,000 / an additional $0 - $30,000]
[Total][Out-of-Pocket (OOP) Limits each [Calendar Year] [Plan Year][*]			[$0 - $25,000]
[[All Out-of-Pocket Limits are calculated separately.] [Applicable Out-of-Pocket Limits must be satisfied prior to any payment of Covered Charges.] [Out-of-Pocket Limits do not include Deductible.] [Amounts may be credited to Your Out-of-Pocket Limits based on the Deductible [Credit] [and] [or] [Reward] [and] [or] [Multi Year Deductible] Program.]]			

[* We may adjust this amount periodically to ensure that it is not less than the [minimum] [maximum] amount permitted by federal law.]
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[**Inpatient Medical Facility Services**]:				
[Subject to [Plan] [Integrated] [Per Cause] Deductible] and [Plan] Coinsurance [unless otherwise specified]]				
[Benefits are limited to a Maximum [Lifetime] [Calendar Year] [Plan Year] [Benefit Period] [Per Cause] [Monthly] [Daily] Benefit of [$XXX] [unless due to an [Accidental Injury] [Injury] [or] [underlying Sickness] [then We will pay up to a [$XXX] Maximum [Lifetime] [Calendar Year] [Plan Year] [Benefit Period] [Per Cause] [Monthly] [Daily] Benefit]				
	[Participating Provider [Benefits] / Network Provider [Benefits]]	**[[Select] Participating Provider [Benefits]]**	**[Participating Provider [Benefits] / Network Provider [Benefits]]**	**[Non-[Select] Participating Provider [Benefits]/ Non-Participating Provider [Benefits]/ Non-Network Provider [Benefits]]**
[[Inpatient Medical Facility Services] Maximum Benefit]	[$XXX] [Per Covered Person]	[$XXX] [Per Covered Person]	[$XXX] [Per Covered Person]	[$XXX] [Per Covered Person]
[[Inpatient Medical Facility Services] Maximum Benefit] [due to an [Accidental Injury] [Injury] [or] [underlying Sickness]	$XXX] [Per Covered Person	$XXX] [Per Covered Person]	[$XXX] [Per Covered Person]	[$XXX] [Per Covered Person]
[[Inpatient Medical Facility Services Deductible] [each [Calendar Year] [Benefit Period] [Time Period] [Plan Year] [Individual] [Integrated] [Family]	 [$XXX] [$XXX]	 [$XXX] [$XXX]	 [$XXX] [$XXX]	 [$XXX] [$XXX]
[The [Inpatient Medical Facility Services Deductible] does [not] apply to the [Plan] [Integrated] [Per Cause] Deductible or Total [Plan] Out-of-Pocket Limits.]				
[[Non-Participating] [Non-Network] Provider Deductible is in addition to the Participating Provider Deductible.]				
[[Emergency Room Copayment applies only to the Emergency Room charges.] [Once this amount is paid, We will pay the remaining Emergency Room charge at [100%].] [All other covered charges associated with the Emergency Room visit will be subject to the [Plan] [Integrated] [Per Cause] [and] [Inpatient Medical Facility Services] [Deductible] and [Plan] [and] [Inpatient Medical Facility Services] Coinsurance [unless otherwise specified.]]				
[Once [[2] or more Covered Persons have collectively met] the maximum Family Deductible [has been met]], no additional Deductible will be taken during the [Calendar Year] [Plan Year] [Benefit Period] [Time Period].]				
[[Facility] [Copayment]]	[None / $XXX per Inpatient confinement]	[None / $XXX per Inpatient confinement]	[None / $XXX per Inpatient confinement]	[None / $XXX per Inpatient confinement]
[Facility] [Access] [Fee]	[[$XXX] per Inpatient confinement] [Per Day] [up to [xx] days]]	[[$XXX] per Inpatient confinement] [Per Day] [up to [xx] days]]	[[$XXX] per Inpatient confinement] [Per Day] [up to [xx] days]]	[[$XXX] per Inpatient confinement] [Per Day] [up to [xx] days]]
[Emergency Room] [Access] [Fee]	[[$XXX] per Emergency Room visit] [Waived if admitted]	[[$XXX] per Emergency Room visit] [Waived if	[[$XXX] per Emergency Room visit] [Waived if admitted]	[[$XXX] per Emergency Room visit] [Waived if admitted]

		admitted]		
[Emergency Room] [Copayment]	[[$XXX] per Emergency Room visit] [Waived if admitted]	[[$XXX] per Emergency Room visit] [Waived if admitted]	[[$XXX] per Emergency Room visit] [Waived if admitted]	[Subject to [Plan] [and] [Outpatient] [Integrated] [Per Cause] Deductible] and [Plan] [and] [Outpatient] Coinsurance [unless otherwise specified].]
[Inpatient Medical Facility Services] [Coinsurance] [Tier [1]]	[0% - 100% [until the [Inpatient Medical Facility Services] [Tier [1]] Out-of-Pocket Limits are satisfied; [then Tier [2];] [100% thereafter.]]	[0% - 100% [until the [Inpatient Medical Facility Services] [Tier [1]] Out-of-Pocket Limits are satisfied; [then Tier [2];] [100% thereafter.]]	[0% - 100% [until the [Inpatient Medical Facility Services] [Tier [1]] Out-of-Pocket Limits are satisfied; [then Tier [2];] [100% thereafter.]]	[0% - 100% [until the [Inpatient Medical Facility Services] [Tier [1]] Out-of-Pocket Limits are satisfied; [then Tier [2];] [100% thereafter.]]
[Tier [1]] [Inpatient Medical Facility Services] [Out-of-Pocket Limit] [each [Calendar Year] [Benefit Period] [Time Period] [Plan Year] [Individual]	[$0 - $25,000 / Not applicable]	[$0 - $25,000 / Not applicable]	[$0 - $25,000 / Not applicable]	[$0 - $25,000 / an additional $0 - $10,000]
[Family]	[$0 - $75,000 / Not applicable]	[$0 - $75,000 / Not applicable]	[$0 - $75,000 / Not applicable]	[$0 - $75,000 / an additional $0 - $30,000]
[Inpatient Medical Facility Services] [Coinsurance] [Tier [2]]	[0% - 100% [until the [Inpatient Medical Facility Services] [Tier [2]] Out-of-Pocket Limits are satisfied; [then Tier [X];] [100% thereafter.]]	[0% - 100% [until the [Inpatient Medical Facility Services] [Tier [2]] Out-of-Pocket Limits are satisfied; [then Tier [X];] [100% thereafter.]]	[0% - 100% [until the [Inpatient Medical Facility Services] [Tier [2]] Out-of-Pocket Limits are satisfied; [then Tier [X];] [100% thereafter.]]	[0% - 100% [until the [Inpatient Medical Facility Services] [Tier [2]] Out-of-Pocket Limits are satisfied; [then Tier [X];] [100% thereafter.]]
[Tier [2]] [Inpatient Medical Facility Services] [Out-of-Pocket Limit][each [Calendar Year] [Benefit Period] [Time Period] [Plan Year] [Individual]	[$0 - $25,000 / Not applicable]	[$0 - $25,000 / Not applicable]	[$0 - $25,000 / Not applicable]	[$0 - $25,000 / an additional $0 - $10,000]
[Family]	[$0 - $75,000 / Not applicable]	[$0 - $75,000 / Not applicable]	[$0 - $75,000 / Not applicable]	[$0 - $75,000 / an additional

				$0 - $30,000]
[Inpatient Medical Facility Services] [Coinsurance] [Tier [X]]	[0% - 100% [until the [Inpatient Medical Facility Services] [Tier [X]] Out-of-Pocket Limits are satisfied;] [then Tier [X + [1]];] [100% thereafter.]]	[0% - 100% [until the [Inpatient Medical Facility Services] [Tier [X]] Out-of-Pocket Limits are satisfied;] [then Tier [X + [1]];] [100% thereafter.]]	[0% - 100% [until the [Inpatient Medical Facility Services] [Tier [X]] Out-of-Pocket Limits are satisfied;] [then Tier [X + [1]];] [100% thereafter.]]	[0% - 100% [until the [Inpatient Medical Facility Services] [Tier [X]] Out-of-Pocket Limits are satisfied;] [then Tier [X + [1]];] [100% thereafter.]]
[Tier [X]] [Inpatient Medical Facility Services] [Out-of-Pocket Limit][each [Calendar Year] [Benefit Period] [Time Period] [Plan Year] [Individual] [Family]	 [$0 - $25,000 / Not applicable] [$0 - $75,000 / Not applicable]	 [$0 - $25,000 / Not applicable] [$0 - $75,000 / Not applicable]	 [$0 - $25,000 / Not applicable] [$0 - $75,000 / Not applicable]	 [$0 - $25,000 / an additional $0 - $10,000] [$0 - $75,000 / an additional $0 - $30,000]
[[Inpatient Medical Facility Services] [Out-of-Pocket Limits] [each] [Calendar Year] [Benefit Period] [Time Period] [Plan Year] [Individual] [Family]	 [$XXX] [$XXX]	 [$XXX] [$XXX]	 [$XXX] [$XXX]	 [$XXX] [$XXX]

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[**Outpatient Medical Facility Services**:]
[All Outpatient services, supplies and treatments apply to the [Outpatient] [Plan Year] [Per Cause] [Calendar Year] Maximum Benefit [including] [excluding] Outpatient Prescription Drugs.]
[Limited to Outpatient Services associated with an Inpatient Stay when Covered Charges are Incurred within [14 days] of admission.]
[Subject to [Plan] [and] [Outpatient Services] [Integrated] [Per Cause] Deductible] and [Plan] [and] [Outpatient Services] [Outpatient] Coinsurance [unless otherwise specified]]
[Benefits are limited to an Outpatient [Calendar Year] Maximum [Lifetime] [Calendar Year] [Plan Year] [Benefit Period] [Per Cause] [Monthly] [Daily] Benefit of [$XXX] per [Covered Person] [covered child] [Family] [unless due to an] [Accidental Injury] [Injury] [or] [underlying Sickness] [then We will pay up to a[$XXX] Maximum [Lifetime] [Calendar Year] [Plan Year] [Benefit Period] [Per Cause] [Monthly] [Daily] Benefit]]
[We will pay [up to] an Outpatient Maximum of [$XXX] [per][Covered Person] [covered child] per [day] [episode] [unless due to an [Accidental Injury] [Injury] [or] [underlying Sickness] [then We will pay up to [$XXX] per [day] [episode]]

[Emergency Room] Benefits are limited to a [Lifetime] [Calendar Year] [Plan Year] [Benefit Period] [Per Cause] [Monthly] [Daily] [per] [episode] Maximum Benefit of [$XXX] [per] [Covered Person] [covered child] [Family]]
[The [Emergency Room] [Access] [Fee] [Copayment] will [not] apply toward any Out-of-Pocket Limit]
[The [Emergency Room] [Access] [Fee] [Copayment] will be waived if the Covered Person is subsequently admitted to the hospital for an Inpatient Stay.]
[[Emergency Room Copayment applies only to the Emergency Room charges.] [Once this amount is paid, We will pay the remaining Emergency Room charge at [100%].] [All other covered charges associated with the Emergency Room visit will be subject to the [Plan] [Integrated] [Per Cause] [and] [Inpatient Medical Facility Services] [Deductible] and [Plan] [and] [Inpatient Medical Facility Services] Coinsurance [unless otherwise specified.]]
[Non-Emergency use of an Emergency Room will result in a [30%] reduction in Covered Charges]

	[[Select] Participating Provider [Benefits]]	**[Participating Provider [Benefits] / Network Provider [Benefits]]**	**[Non-[Select] Participating Provider [Benefits]/ Non-Participating Provider [Benefits]/ Non-Network Provider [Benefits]]**
[[Outpatient [Services] Maximum Benefit]	$[XXX] [Per Covered Person]	$[XXX] [Per Covered Person]	$[XXX] [Per Covered Person]
[[Outpatient Services] Maximum Benefit] [due to an [Accidental Injury] [Injury] [or] [underlying Sickness]]	$[XXX] [Per Covered Person]	$[XXX] [Per Covered Person]	$[XXX] [Per Covered Person]
[[Outpatient [Surgical] [Services] [Per Cause] Deductible] [each [Calendar Year] [Benefit Period] [Time Period] [Plan Year] [Individual] [Integrated] [Family]	 [$XXX / None] [$XXX / None]	 [$XXX / None] [$XXX / None]	 [$XXX / None] [$XXX / None]
[The [Outpatient [Surgical] Services] Deductible] does [not] apply to the [Plan] [Integrated] [Per Cause] Deductible] or Total [Plan] Out-of-Pocket Limits.]			
[[Non-Participating] [Non-Network] Provider Deductible is in addition to the [Participating] [Network] Provider Deductible.]			
[Once [[2] or more Covered Persons have collectively met] the maximum Family Deductible [has been met]], no additional Deductible will be taken during the [Calendar Year] [Plan Year] [Benefit Period] [Time Period].]			
[Facility] [Access] [Fee]	[None] [[$XXX] [per Outpatient Surgical Service]]	[None] [[$XXX] [per Outpatient Surgical Service]]	[None] [[$XXX] [per Outpatient Surgical Service]]
[Emergency Room [Access] [Fee]	[None] [[$XXX] [per Emergency Room Visit]]	[None] [[$XXX] [per Emergency Room Visit]]	[None] [[$XXX] [per Emergency Room Visit]]
[Facility] [Emergency Room] [Copayment]	[None] [[$XXX] [per Outpatient Surgical Service]]	[None] [[$XXX] [per Outpatient Surgical Service]]	[Subject to [Plan] [and] [Outpatient] [Integrated] [Per Cause] Deductible] and [Plan] [and] [Outpatient] Coinsurance [unless otherwise specified].]
[[Outpatient [Surgical] Services] [Coinsurance]] [Tier [1]]	[0% - 100% [until the [[Outpatient [Surgical] Services]] [Tier [1]] Out-of-Pocket Limits are satisfied; [then Tier [2];] [100% thereafter.]]	[0% - 100% [until the [[Outpatient [Surgical] Services] [Tier [1]] Out-of-Pocket Limits are satisfied; [then Tier [2];] [100% thereafter.]]	[0% - 100% [until the [[Outpatient [Surgical] Services] [Tier [1]] Out-of-Pocket Limits are satisfied; [then Tier [2];] [100% thereafter.]]

[Tier [1]] [[Outpatient [Surgical] Services] [Out-of-Pocket Limit] [each [Calendar Year] [Benefit Period] [Time Period] [Plan Year]] [Individual]	[$0 - $25,000 / Not applicable]	[$0 - $25,000 / Not applicable]	[$0 - $25,000 / an additional $0 - $10,000]
[Family]	[$0 - $75,000 / Not applicable]	[$0 - $75,000 / Not applicable]	[$0 - $75,000 / an additional $0 - $30,000]
[[Outpatient [Surgical] Services] [Coinsurance]] [Tier [2]]	[0% - 100% [until the [[Outpatient [Surgical] Services] [Tier [2]] Out-of-Pocket Limits are satisfied; [then Tier [X];] [100% thereafter.]]	[0% - 100% [until the [[Outpatient [Surgical] Services] [Tier [2]] Out-of-Pocket Limits are satisfied; [then Tier [X];] [100% thereafter.]]	[0% - 100% [until the [[Outpatient [Surgical] Services] [Tier [2]] Out-of-Pocket Limits are satisfied; [then Tier [X];] [100% thereafter.]]
[Tier [2]] [[Outpatient [Surgical] Services] [Out-of-Pocket Limit] [each [Calendar Year] [Benefit Period] [Time Period] [Plan Year]] [Individual]	[$0 - $25,000 / Not applicable]	[$0 - $25,000 / Not applicable]	[$0 - $25,000 / an additional $0 - $10,000]
[Family]	[$0 - $75,000 / Not applicable]	[$0 - $75,000 / Not applicable]	[$0 - $75,000 / an additional $0 - $30,000]
[[Outpatient [Surgical] Services] [Coinsurance]] [Tier [X]]	[0% - 100% [until the [[Outpatient [Surgical] Services] [Tier [X]] Out-of-Pocket Limits are satisfied;] [then Tier [X + [1]];] [100% thereafter.]]	[0% - 100% [until the [[Outpatient [Surgical] Services] [Tier [X]] Out-of-Pocket Limits are satisfied;] [then Tier [X + [1]];] [100% thereafter.]]	[0% - 100%[then Tier [X + [1]];] [until the [[Outpatient [Surgical] Services] [Tier [X]] Out-of-Pocket Limits are satisfied;] [then Tier [X + [1]];] [100% thereafter.]]
[Tier [X]] [[Outpatient [Surgical] Services] [Out-of-Pocket Limit] [each [Calendar Year] [Benefit Period] [Time Period] [Plan Year]] [Individual]	[$0 - $25,000 / Not applicable]	[$0 - $25,000 / Not applicable]	[$0 - $25,000 / an additional $0 - $10,000]
[Family]	[$0 - $75,000 / Not applicable]	[$0 - $75,000 / Not applicable]	[$0 - $75,000 / an additional $0 - $30,000]
[[Outpatient [Surgical] Services] Out-of-Pocket Limits] [each [Calendar Year] [Benefit Period] [Time Period] [Plan Year]] [Individual]	[$XXX]	[$XXX]	[$XXX]

[Family]	[$XXX]	[$XXX]	[$XXX]

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[**Physician**][**Doctor**] [**Office Visit**]:
[All services, supplies and treatments apply to the [Outpatient] [and] [Calendar Year] [and] [Plan Year] [Benefit Period] [Per Cause] Maximum Benefit.]
[Subject to [Plan] [and] [Outpatient] [Integrated] [Per Cause] Deductible] and [Plan] [and] [Outpatient] Coinsurance [unless otherwise specified].]
[After [XX] [Primary Care Provider] Office Visit[s] [or] [Retail Health Clinic visit[s]] in a [Calendar Year] [Plan Year] [Benefit Period] [Per Cause] [month] [per] [Covered Person] [per covered child], Covered Charges will be subject to the [Plan [Per Cause] Deductible,] [and] [Outpatient Deductible,] [and] [Outpatient] [Coinsurance].]
[After application of the [Primary Care Provider] Copayment, Covered Charges for [Primary Care Provider] Office Visits [or] [Retail Health Clinic visits] will be subject to the [Plan],[and] [Outpatient] [Per Cause] Deductible,] [and] [Outpatient] [Coinsurance].]
[After [XX] [Designated Specialty Care Provider] Office Visit[s] [or] [Retail Health Clinic visit[s]] in a [Calendar Year] [Plan Year] [Benefit Period] [Per Cause] [month] [per] [Covered Person] [per covered child], Covered Charges will be subject to the [Plan [Per Cause] Deductible],] [Outpatient Deductible,] [and] [Outpatient] [Coinsurance].]
[After application of the [Designated Specialty Care Provider] Copayment, Covered Charges for [Designated Specialty Care Provider] Office Visits [or] [Retail Health Clinic visits] will be subject to the [Plan [Per Cause] Deductible],] [Outpatient Deductible,] [and] [Outpatient] [Coinsurance].]
[After [XX] [Mid-Level Practitioner] Office Visit[s] [or] [Retail Health Clinic visit[s]] in a [Calendar Year] [Plan Year] [Benefit Period] [Per Cause] [month] [per] [Covered Person] [per covered child], Covered Charges will be subject to the [Plan [Per Cause] Deductible],] [Outpatient Deductible,] [and] [Outpatient] [Coinsurance].]
[After application of the [Mid-Level Practitioner] Copayment, Covered Charge for [Mid-Level Practitioner] Office Visits [or] [Retail Health Clinic visits] will be subject to the [Plan [Per Cause] Deductible],] [Outpatient Deductible,] [and] [Outpatient] [Coinsurance].]
[After [XX] [Retail Health Clinic visit[s]] in a [Calendar Year] [Plan Year] [Benefit Period] [Per Cause] [month] [per] [Covered Person] [per covered child], Covered Charges will be subject to the [Plan [Per Cause] Deductible],] [Outpatient Deductible,] [and] [Outpatient] [Coinsurance].]
[After application of the [Retail Health Clinic visit[s]] Copayment, Covered Charges [for Retail Health Clinic visits] will be subject to the [Plan [Per Cause] Deductible],] [Outpatient Deductible,] [and] [Outpatient] [Coinsurance].]
[[Physician][Doctor] [Office Visit] [or] [Retail Health Clinic visit] Copayments will [not] apply toward any Out-of-Pocket Limits].]
[[Physician][Doctor] [Office Visit] [or] [Retail Health Clinic visit] [Copayment] Includes the first [$50 - $200] of a [Select Participating Provider] [Participating Provider] Diagnostic Imaging Services] [per Covered Person] [Per Covered Child] [per [Calendar Year] [Plan Year] [Benefit Period] [Per Cause].]
[Benefits for [Physician][Doctor] Office Visits [or] [Retail Health Clinic visits] are limited to [[2] visits each [Calendar Year] [Plan Year] [Benefit Period] [Per Cause] per Covered [Person][Child] with] a maximum payment of [$25 - $100] per visit.] [After that, Office Visits [or] [Retail Health Clinic visits] are subject to the [Plan [Per Cause] Deductible],] [Outpatient Deductible,] [and] [Outpatient] [Coinsurance].]
[[Physician][Doctor] [Office Visits] [or] [Retail Health Clinic visits] [Copayment] Benefit Waiting Period is [[12] months] [[365] days].]

	[[Select] Participating Provider [Benefits]]	**[Participating Provider [Benefits] / Network Provider [Benefits]]**	**[Non-[Select] Participating Provider [Benefits]/ Non-Participating Provider [Benefits]/ Non-Network Provider [Benefits]]**
[Physician][Doctor] [Mid-Level Practitioner] [Office Visit] [Retail Health Clinic visit] Maximum [Lifetime] [Calendar Year] [Plan	[$XXX] [per Covered Person] [Per Covered Child]	[$XXX] [per Covered Person] [Per Covered Child]	[$XXX] [per Covered Person] [Per Covered Child]

Year] [Benefit Period] [Per Cause] [Monthly] [Daily] Benefit]			
[Physician][Doctor] [Mid-Level Practitioner] [Office Visit] [Retail Health Clinic visit] Maximum [Lifetime] [Calendar Year] [Plan Year] [Benefit Period] [Per Cause] [Monthly] [Daily] Benefit]	[$XXX] [per Covered Person] [Per Covered Child]	[$XXX] [per Covered Person] [Per Covered Child]	[$XXX] [per Covered Person] [Per Covered Child]
[Physician][Doctor] [Mid-Level Practitioner] [Office Visit Deductible] [Retail Health Clinic visit Deductible] [Individual] [Per Covered Child]	[$XXX]	[$XXX]	[$XXX]
[Integrated] [Family]	[$XXX]	[$XXX]	[$XXX]
[Physician][Doctor] [Mid-Level Practitioner] [Office Visit Deductible] [Retail Health Clinic visit Deductible] [Individual] [Per Covered Child]	[$XXX]	[$XXX]	[$XXX]
[Integrated] [Family]	[$XXX]	[$XXX]	[$XXX]
[The [Physician][Doctor] [Mid-Level Practitioner] [Office Visit Deductible] [Retail Health Clinic visit Deductible] does [not] apply to the Plan Deductible or Total Out-of-Pocket Limits.]			
[[Non-Participating] [Non-network] Provider Deductible is in addition to the [Participating] [Network] Provider Deductible.]			
[Once [[2] or more Covered Persons have collectively met] the maximum Family Deductible [has been met], no additional Deductible will be taken during the [Calendar Year] [Plan Year] [Benefit Period] [Time Period].]			
[Tiered] [Copayment:][After Copayment, [Participating] [Network] [Select] Office Visits [Retail Health Clinic visits] paid at 100%] [Primary Care Provider]	[None] [$5 - $65 per office visit] [for up to [X] visits] [per Calendar Year] [for the first [1-30] visits] [in the first [[Calendar] [Plan] [Year] [Benefit Period]] [and] [,] [$5-$65][for the next [1-30] visits] [in the second [[Calendar] [Plan] Year] [Benefit Period]] [and [$5-$65] [for the next [1-30] visits] [in the subsequent [[Calendar] [Plan] Years] [Benefit Period]] [per [Covered Person] [covered child]] [per [Calendar] [Plan]	[None] [$5 - $65 per office visit] [for up to [X] visits] [per Calendar Year] [for the first [1-30] visits] [in the first [[Calendar] [Plan] [Year] [Benefit Period]] [and] [,] [$5-$65][for the next [1-30] visits] [in the second [[Calendar] [Plan] Year] [Benefit Period]] [and [$5-$65] [for the next [1-30] visits] [in the subsequent [[Calendar] [Plan] Years] [Benefit Period]] [per [Covered Person] [covered child]] [per [Calendar] [Plan]	[Subject to [Designated Specialty Provider] [Plan] [Outpatient] [Integrated] [[Per Cause] [Deductible]] [and] [Outpatient] [Coinsurance]

	Year] [Additional Office Visits are][Additional Retail Health Clinic visits are][subject to [Designated Specialty Provider] [Plan] [Outpatient] [Integrated] [[Per Cause] [Deductible]] [and] [Outpatient] [Coinsurance]]	Year] [Additional Office Visits are] [Additional Retail Health Clinic visits are] [subject to [Designated Specialty Provider] [Plan] [Outpatient] [Integrated] [[Per Cause] [Deductible]] [and] [Outpatient] [Coinsurance]]	
[Designated Specialty Care Provider]	[None] [$5 - $65 per office visit] [for up to [X] visits] [per Calendar Year] [for the first [1-30] visits] [in the first [[Calendar] [Plan] [Year] [Benefit Period]] [and] [,] [$5-$65][for the next [1-30] visits] [in the second [[Calendar] [Plan] Year] [Benefit Period]] [and [$5-$65] [for the next [1-30] visits] [in the subsequent [[Calendar] [Plan] Years] [Benefit Period]] [per [Covered Person] [covered child]] [per [Calendar] [Plan] Year] [Additional Office Visits are] [Additional Retail Health Clinic visits are][subject to [Designated Specialty Provider] [Plan] [Outpatient] [Integrated] [[Per Cause [Deductible]] [and] [Outpatient] [Coinsurance]]	[None] [$5 - $65 per office visit] [for up to [X] visits] [per Calendar Year] [for the first [1-30] visits] [in the first [[Calendar] [Plan] [Year] [Benefit Period]] [and] [,] [$5-$65][for the next [1-30] visits] [in the second [[Calendar] [Plan] Year] [Benefit Period]] [and [$5-$65] [for the next [1-30] visits] [in the subsequent [[Calendar] [Plan] Years] [Benefit Period]] [per [Covered Person] [covered child]] [per [Calendar] [Plan] Year] [Additional Office Visits are] [Additional Retail Health Clinic visits are][subject to [Designated Specialty Provider] [Plan] [Outpatient] [Integrated] [[Per Cause] [Deductible]] [and] [Outpatient] [Coinsurance]]	[Subject to [Designated Specialty Provider] [Plan] [Outpatient] [Integrated] [[Per Cause] [Deductible] [and] [Outpatient] [Coinsurance]
[Mid-Level Practitioner]	[None] [$5 - $65 per office visit] [for up to [X] visits] [per Calendar Year] [for the first [1-30] visits] [in the first [[Calendar] [Plan] [Year] [Benefit Period]] [and] [,] [$5-$65][for the next [1-30] visits] [in the second [[Calendar] [Plan] Year] [Benefit Period]] [and [$5-$65]	[None] [$5 - $65 per office visit] [for up to [X] visits] [per Calendar Year] [for the first [1-30] visits] [in the first [[Calendar] [Plan] [Year] [Benefit Period]] [and] [,] [$5-$65][for the next [1-30] visits] [in the second [[Calendar] [Plan] Year] [Benefit Period]] [and [$5-$65]	[Subject to [Designated Specialty Provider] [Plan] [Outpatient] [Integrated] [[Per Cause] [Deductible]] [and] [Outpatient] [Coinsurance]

	[for the next [1-30] visits] [in the subsequent [[Calendar] [Plan] Years] [Benefit Period]] [per [Covered Person] [covered child]] [per [Calendar] [Plan] Year] [Additional Office Visits are] [Additional Retail Health Clinic visits are][subject to [Designated Specialty Provider] [Plan] [Outpatient] [Integrated] [[Per Cause] [Deductible]] [and] [Outpatient] [Coinsurance]]	[for the next [1-30] visits] [in the subsequent [[Calendar] [Plan] Years] [Benefit Period]] [per [Covered Person] [covered child]] [per [Calendar] [Plan] Year] [Additional Office Visits are] [Additional Retail Health Clinic visits are][subject to [Designated Specialty Provider] [Integrated] [Plan] [Outpatient] [[Per Cause] [Deductible]] [and] [Outpatient] [Coinsurance]]	
[Retail Health Clinic]	[None] [$5 - $65 per office visit] [for up to [X] visits] [per Calendar Year] [for the first [1-30] visits] [in the first [[Calendar] [Plan] [Year] [Benefit Period]] [and] [,] [$5-$65] [for the next [1-30] visits] [in the second [[Calendar] [Plan] Year] [Benefit Period]] [and [$5-$65] [for the next [1-30] visits] [in the subsequent [[Calendar] [Plan] Years] [Benefit Period]] [per [Covered Person] [covered child]] [per [Calendar] [Plan] Year] [Additional Office Visits are] [Additional Retail Health Clinic visits are][subject to [Designated Specialty Provider] [Plan] [Outpatient] [Integrated] [[Per Cause] [Deductible]] [and] [Outpatient] [Coinsurance]]	[None] [$5 - $65 per office visit] [for up to [X] visits] [per Calendar Year] [for the first [1-30] visits] [in the first [[Calendar] [Plan] [Year] [Benefit Period]] [and] [,] [$5-$65] [for the next [1-30] visits] [in the second [[Calendar] [Plan] Year] [Benefit Period]] [and [$5-$65] [for the next [1-30] visits] [in the subsequent [[Calendar] [Plan] Years] [Benefit Period]] [per [Covered Person] [covered child]] [per [Calendar] [Plan] Year] [Additional Office Visits are] [Additional Retail Health Clinic visits are] [subject to [Designated Specialty Provider] [Integrated] [Plan] [Outpatient] [[Per Cause] [Deductible]] [and] [Outpatient] [Coinsurance]]	[Subject to [Designated Specialty Provider] [Plan] [Outpatient] [Integrated] [[Per Cause] [Deductible]] [and] [Outpatient] [Coinsurance]
[Tiered] [Copayment:][After Copayment, [Participating] [Network] [Select] Office Visits [Retail Health Clinic visit] paid at 100%]			

Primary Care Provider]	[None] [$5 - $65 per office visit] [for up to [X] visits] [per Calendar Year] [for the first [1-30] visits] [in the first [[Calendar] [Plan] [Year] [Benefit Period]] [and] [,] [$5-$65][for the next [1-30] visits] [in the second [[Calendar] [Plan] Year] [Benefit Period]] [and [$5-$65] [for the next [1-30] visits] [in the subsequent [[Calendar] [Plan] Years] [Benefit Period]] [per [Covered Person] [covered child]] [per [Calendar] [Plan] Year] [Additional Office Visits are] [Additional Retail Health Clinic visits are][subject to [Designated Specialty Provider] [Plan] [Outpatient] [Integrated] [[Per Cause] [Deductible]] [and] [Outpatient] [Outpatient] [Coinsurance]]	[None] [$5 - $65 per office visit] [for up to [X] visits] [per Calendar Year] [for the first [1-30] visits] [in the first [[Calendar] [Plan] [Year] [Benefit Period]] [and] [,] [$5-$65][for the next [1-30] visits] [in the second [[Calendar] [Plan] Year] [Benefit Period]] [and [$5-$65] [for the next [1-30] visits] [in the subsequent [[Calendar] [Plan] Years] [Benefit Period]] [per [Covered Person] [covered child]] [per [Calendar] [Plan] Year] [Additional Office Visits are] [Additional Retail Health Clinic visits are][subject to [Designated Specialty Provider] [Plan] [Outpatient] [Integrated] [[Per Cause] [Deductible]] [and] [Outpatient] [Outpatient] [Coinsurance]]	[Subject to [Designated Specialty Provider] [Plan] [Outpatient] [Integrated] [[Per Cause] [Deductible]] [and] [Outpatient] [Coinsurance]
[Designated Specialty Care Provider]	[None] [$5 - $65 per office visit] [for up to [X] visits] [per Calendar Year] [for the first [1-30] visits] [in the first [[Calendar] [Plan] [Year] [Benefit Period]] [and] [,] [$5-$65][for the next [1-30] visits] [in the second [[Calendar] [Plan] Year] [Benefit Period]] [and [$5-$65] [for the next [1-30] visits] [in the subsequent [[Calendar] [Plan] Years] [Benefit Period]] [per [Covered Person] [covered child]] [per [Calendar] [Plan] Year] [Additional Office Visits are] [Additional Retail Health Clinic visits are][subject to [Designated Specialty	[None] [$5 - $65 per office visit] [for up to [X] visits] [per Calendar Year] [for the first [1-30] visits] [in the first [[Calendar] [Plan] [Year] [Benefit Period]] [and] [,] [$5-$65][for the next [1-30] visits] [in the second [[Calendar] [Plan] Year] [Benefit Period]] [and [$5-$65] [for the next [1-30] visits] [in the subsequent [[Calendar] [Plan] Years] [Benefit Period]] [per [Covered Person] [covered child]] [per [Calendar] [Plan] Year] [Additional Office Visits are] [Additional Retail Health Clinic visits are][subject to [Designated Specialty	[Subject to [Designated Specialty Provider] [Plan] [Outpatient] [Integrated] [[Per Cause] [Deductible] [and] [Coinsurance]

	Provider] [Plan] [Outpatient] [Integrated] [[Per Cause [Deductible]] [and] [Outpatient] [Coinsurance]]	Provider] [Plan] [Outpatient] [Integrated] [[Per Cause] [Deductible]] [and] [Outpatient] [Coinsurance]]	
[Mid-Level Practitioner]	[None] [$5 - $65 per office visit] [for up to [X] visits] [per Calendar Year] [for the first [1-30] visits] [in the first [[Calendar] [Plan] [Year] [Benefit Period]] [and] [,] [$5-$65][for the next [1-30] visits] [in the second [[Calendar] [Plan] Year] [Benefit Period]] [and [$5-$65] [for the next [1-30] visits] [in the subsequent [[Calendar] [Plan] Years] [Benefit Period]] [per [Covered Person] [covered child]] [per [Calendar] [Plan] Year] [Additional Office Visits are] [Additional Retail Health Clinic visits are][subject to [Designated Specialty Provider] [Plan] [Outpatient] [Integrated] [[Per Cause] [Deductible]] [and] [Outpatient] [Coinsurance]]	[None] [$5 - $65 per office visit] [for up to [X] visits] [per Calendar Year] [for the first [1-30] visits] [in the first [[Calendar] [Plan] [Year] [Benefit Period]] [and] [,] [$5-$65][for the next [1-30] visits] [in the second [[Calendar] [Plan] Year] [Benefit Period]] [and [$5-$65] [for the next [1-30] visits] [in the subsequent [[Calendar] [Plan] Years] [Benefit Period]] [per [Covered Person] [covered child]] [per [Calendar] [Plan] Year] [Additional Office Visits are] [Additional Retail Health Clinic visits are][subject to [Designated Specialty Provider] [Integrated] [Plan] [Outpatient] [[Per Cause] [Deductible]] [and] [Outpatient] [Coinsurance]]	[Subject to [Designated Specialty Provider] [Plan] [Outpatient] [Integrated] [[Per Cause] [Deductible]] [and] [Outpatient] [Coinsurance]
[Retail Health Clinic]	[None] [$5 - $65 per office visit] [for up to [X] visits] [per Calendar Year] [for the first [1-30] visits] [in the first [[Calendar] [Plan] [Year] [Benefit Period]] [and] [,] [$5-$65] [for the next [1-30] visits] [in the second [[Calendar] [Plan] Year] [Benefit Period]] [and [$5-$65] [for the next [1-30] visits] [in the subsequent [[Calendar] [Plan] Years] [Benefit Period]] [per [Covered	[None] [$5 - $65 per office visit] [for up to [X] visits] [per Calendar Year] [for the first [1-30] visits] [in the first [[Calendar] [Plan] [Year] [Benefit Period]] [and] [,] [$5-$65] [for the next [1-30] visits] [in the second [[Calendar] [Plan] Year] [Benefit Period]] [and [$5-$65] [for the next [1-30] visits] [in the subsequent [[Calendar] [Plan] Years] [Benefit Period]] [per [Covered	[Subject to [Designated Specialty Provider] [Plan] [Outpatient] [Integrated] [[Per Cause] [Deductible]] [and] [Outpatient] [Coinsurance]

	Person] [covered child]] [per [Calendar] [Plan] Year] [Additional Office Visits are] [Additional Retail Health Clinic visits are][subject to [Designated Specialty Provider] [Plan] [Outpatient] [Integrated] [[Per Cause] [Deductible]] [and] [Outpatient] [Coinsurance]]	Person] [covered child]] [per [Calendar] [Plan] Year] [Additional Office Visits are] [Additional Retail Health Clinic visits are][subject to [Designated Specialty Provider] [Integrated] [Plan] [Outpatient] [[Per Cause] [Deductible]] [and] [Outpatient] [Coinsurance]]	
[Physician][Doctor] [Office Visit] [Retail Health Clinic visit] [Coinsurance] [Tier [1]]	[0% - 100% [until the [Office Visit] [Retail Health Clinic visit] [Tier [1]] Out-of-Pocket Limits are satisfied; [then Tier [2];] [100% thereafter.]]	[0% - 100% [until the [Office Visit] [Retail Health Clinic visit] [Tier [1]] Out-of-Pocket Limits are satisfied; [then Tier [2];] [100% thereafter.]]	[0% - 100% [until the [Office Visit] [Retail Health Clinic visit] [Tier [1]] Out-of-Pocket Limits are satisfied; [then Tier [2];] [100% thereafter.]]
[Tier [1]] [Physician][Doctor] [Office Visit] [Retail Health Clinic visit] [Out-of-Pocket Limit][each [Calendar Year] [Benefit Period] [Time Period] [Plan Year]] [Individual] [Per Covered Child]	[$0 - $25,000 / Not applicable]	[$0 - $25,000 / Not applicable]	[$0 - $25,000 / an additional $0 - $10,000]
[Family]	[$0 - $75,000 / Not applicable]	[$0 - $75,000 / Not applicable]	[$0 - $75,000 / an additional $0 - $30,000]
[Physician][Doctor] [Office Visit] [Retail Health Clinic visit] [Coinsurance] [Tier [2]]	[0% - 100% [until the [Office Visit] [Retail Health Clinic visit] [Tier [2]] Out-of-Pocket Limits are satisfied; [then Tier [X];] [100% thereafter.]]	[0% - 100% [until the] [Office Visit] [Retail Health Clinic visit] [Tier [2]] Out-of-Pocket Limits are satisfied; [then Tier [X];] [100% thereafter.]]	[0% - 100% [until the [Office Visit] [Retail Health Clinic visit] [Tier [2]] Out-of-Pocket Limits are satisfied; [then Tier [X];] [100% thereafter.]]
[Tier [2]] [Physician][Doctor] [Office Visit] [Retail Health Clinic visit] Out-of-Pocket Limit [each [Calendar Year] [Benefit Period] [Time Period] [Plan Year]] [Individual] [Per Covered Child]	[$0 - $25,000 / Not applicable]	[$0 - $25,000 / Not applicable]	[$0 - $25,000 / an additional $0 - $10,000]
[Family]	[$0 - $75,000 / Not applicable]	[$0 - $75,000 / Not applicable]	[$0 - $75,000 / an additional $0 - $30,000]

[Physician][Doctor] [Office Visit] [Retail Health Clinic visit] [Coinsurance] [Tier [X]]	[0% - 100% [until the [Office Visit] [Retail Health Clinic visit] [Tier [X]] Out-of-Pocket Limits are satisfied;] [then Tier [X + [1]];] [100% thereafter.]]	[0% - 100% [until the [Office Visit] [Retail Health Clinic visit] [Tier [X]] Out-of-Pocket Limits are satisfied;] [then Tier [X + [1]];] [100% thereafter.]]	[0% - 100% [until the [Office Visit] [Retail Health Clinic visit] [Tier [X]] Out-of-Pocket Limits are satisfied;] [then Tier [X + [1]];] [100% thereafter.]]
[Tier [X]] [Physician][Doctor] [Office Visit] [Retail Health Clinic visit] Out-of-Pocket Limit [each [Calendar Year] [Benefit Period] [Time Period] [Plan Year]]			
[Individual] [Per Covered Child]	[$0 - $25,000 / Not applicable]	[$0 - $25,000 / Not applicable]	[$0 - $25,000 / an additional $0 - $10,000]
[Family]	[$0 - $75,000 / Not applicable]	[$0 - $75,000 / Not applicable]	[$0 - $75,000 / an additional $0 - $30,000]
[[Physician][Doctor] [Office Visit] [Retail Health Clinic visit] Out-of-Pocket Limits]			
[Individual] [Per Covered Child]	[$XXX]	[$XXX]	[$XXX]
[Family]	[$XXX]	[$XXX]	[$XXX]

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[**Retail Health Clinic Visit**:]
[All services, supplies and treatments apply to the [Outpatient] [and] [Calendar Year] [and] [Plan Year] [Benefit Period] [Per Cause] Maximum Benefit.]
[Subject to [Plan] [and] [Outpatient] [Integrated] [Per Cause] Deductible] and [Plan] [and] [Outpatient] Coinsurance [unless otherwise specified].]
[After [XX] [Retail Health Clinic visit[s]] in a [Calendar Year] [Plan Year] [Benefit Period] [Per Cause] [month] [per] [Covered Person] [per covered child], Covered Charges will be subject to the [Plan [Per Cause] Deductible,] [and] [Outpatient Deductible,] [and] [Outpatient] [Coinsurance].]
[After application of the [Retail Health Clinic visit] Copayment, Covered Charges for [Retail Health Clinic visits] will be subject to the [Plan][,] [and] [Outpatient] [Per Cause] Deductible,] [and] [Outpatient] [Coinsurance].]
[[Retail Health Clinic visit] Copayments will [not] apply toward any Out-of-Pocket Limits]
[[Retail Health Clinic visit] [Copayment] includes the first [$50 - $2,100] of a [Select Participating Provider] [Participating Provider] Diagnostic Imaging Services] [per Covered Person] [Per Covered Child] [per [Calendar Year] [Plan Year] [Benefit Period] [Per Cause]]
[Benefits for [Retail Health Clinic visits] are limited to [[XX] visits each [Calendar Year] [Plan Year] [Benefit Period] [Per Cause] per Covered [Person][Child] with] a maximum payment of [$25 - $5,100] per visit.] [After that, Retail Health Clinic visits are subject to the [Plan [Per Cause] Deductible],] [Outpatient Deductible,] [and] [Outpatient] [Coinsurance]].
[[Plan] [Integrated] [Per Cause] Deductible] [and Coinsurance] will be waived for the first [$XXX] [XX visits] of Covered Services performed [by a [Retail Health Clinic] [per] [Covered Person] [covered child] [Family] [per [Calendar Year] [Plan Year] [Benefit Period] [Per Cause] [after a [12 month] [365 day] Benefit Waiting Period] [subject to a [$XX] copayment].]
[[Retail Health Clinic visits] [Copayment] Benefit Waiting Period is [[12] months] [[365] days].]

	[[Select] Participating	**[Participating Provider**	**[Non-[Select]**

	Provider [Benefits]]	**[Benefits] / Network Provider [Benefits]]**	**Participating Provider [Benefits]/ Non-Participating Provider [Benefits]/ Non-Network Provider [Benefits]]**
[Retail Health Clinic visit] Maximum [Lifetime] [Calendar Year] [Plan Year] [Benefit Period] [Per Cause] [Monthly] [Daily] Benefit]	[$XXX] [per Covered Person] [Per Covered Child]	[$XXX] [per Covered Person] [Per Covered Child]	[$XXX] [per Covered Person] [Per Covered Child]
[Retail Health Clinic visit Deductible] [Individual] [Per Covered Child]	[$XXX]	[$XXX]	[$XXX]
[Integrated] [Family]	[$XXX]	[$XXX]	[$XXX]
[The [Retail Health Clinic visit Deductible] does [not] apply to the Plan Deductible or Total Out-of-Pocket Limits.]			
[[Non-Participating] [Non-network] Provider Deductible is in addition to the [Participating] [Network] Provider Deductible.]			
[Once [[2] or more Covered Persons have collectively met] the maximum Family Deductible [has been met], no additional Deductible will be taken during the [Calendar Year] [Plan Year] [Benefit Period] [Time Period].]			
[Copayment:][After Copayment, Retail Health Clinic visits paid at 100%]	[None] [$5 - $65 per Retail Health Clinic visit] [for up to [X] visits] [per Calendar Year] [per [Covered Person] [covered child]] [per [Calendar] [Plan] Year]	[None] [$5 - $65 per Retail Health Clinic visit] [for up to [X] visits] [per Calendar Year] [per [Covered Person] [covered child]] [per [Calendar] [Plan] Year]	[Subject to [Plan] [Outpatient] [Integrated] [[Per Cause] [Deductible]] [and] [Outpatient] [Coinsurance]

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[**Preventive Medicine Services**:]
[All services, supplies and treatments apply to the [Outpatient] [and] [Calendar Year] [and] [Plan Year] [and] [Benefit Period] [Per Cause] Maximum Benefit]
[Subject to [Plan] [and] [Outpatient] [Integrated] [Per Cause] Deductible] and [Plan] [and] [Outpatient] Coinsurance [unless otherwise specified]]
[[Plan] [Integrated] [Per Cause] Deductible] [and Coinsurance] will be waived for the first [$XXX] of Covered Services performed [by a [Participating Provider] [Network Provider] [Retail Health Clinic]] [per] [Covered Person] [covered child] [Family] [per [Calendar Year] [Plan Year] [Benefit Period] [Per Cause] [after a [12 month] Benefit Waiting Period][subject to a [$XX] copayment] [for Mammograms] [and] [, Pap Smears] [and] [Prostate Specific Antigen Screenings] [and] Stool for occult blood testing [and] Flexible sigmoidoscopy and barium enema or colonoscopy [and] Fasting glucose testing] [and] [Lipid profile testing] [and] [Complete blood count (or component parts) testing] [and] [Urinalysis testing] [and] [Tuberculin skin testing with purified protein derivative] [and] [Other diagnostic services as recommended by the United States Preventative Services Task Force on the date the service is Incurred].]
[Benefits for Preventive Medicine Services are limited [to a [$XX] per visit] [up to [XX] visits per] [Calendar Year] [Plan Year] [Monthly] [Daily] [Benefit Period] [Per Cause] [per] [Covered Person] [covered child] [Family].]
[Benefit for Preventive Medicine Services are limited to a Maximum [Lifetime] [Calendar Year] [Plan Year] [Monthly] [Daily] [Benefit Period] [Benefit] of [$XXX] [per [Covered Person] [covered child] [Family].]
[Benefits for Preventive Medicine Services are limited to a Maximum [Lifetime] [Benefit] of [$XXX] [per [Covered Person] [covered child] [Family].]
[Benefits for Preventive Medicine Services are limited to a Maximum Benefit of [[$XX] for each visit] [or] [up to [$XXX] each [Calendar] [Plan] [Benefit] Year] [per [Covered Person] [covered child] [Family].]

[[Mammograms] [Pap Smears] [and] [Prostate Specific Antigen Screenings] Colorectal Cancer Examination [and] [child immunizations up to age [12]] are not subject to the [Preventive Services] [Calendar Year] [Plan Year] [Benefit Period] [Per Cause] Maximum [Lifetime] Benefit]			
[Preventive Medicine Services Benefit Waiting Period is [12] [months] [[365] days].]			
[Not Covered]			
	[[Select] Participating Provider [Benefits]]	**[Participating Provider [Benefits] / Network Provider [Benefits]]**	**[Non-[Select] Participating Provider [Benefits]/ Non-Participating Provider [Benefits]/ Non-Network Provider [Benefits]]**
[[Preventive Medicine Services] Maximum [Lifetime] [Calendar Year] [Plan Year] [Benefit Period] [Per Cause] [Monthly] [Daily] Benefit]	[$XXX] [per Covered Person] [Per Covered Child]	[$XXX] [per Covered Person] [Per Covered Child]	[$XXX] [per Covered Person] [Per Covered Child]
[Preventive Medicine Services Deductible] [Individual] [Per Covered Child] [Integrated] [Family]	[$XXX] [$XXX]	[$XXX] [$XXX]	[$XXX] [$XXX]
[The [Preventive Medicine Services Deductible] does [not] apply to the Plan Deductible or Total Out-of-Pocket Limits.]			
[[Non-Participating] [Non-Network] [Retail Health Clinic] Provider Deductible is in addition to the [Participating] [Network] [Retail Health Clinic] Provider Deductible.]			
[Once [[2] or more Covered Persons have collectively met] the maximum Family Deductible [has been met], no additional Deductible will be taken during the [Calendar Year] [Plan Year] [Benefit Period] [Time Period].]			
[Preventive Medicine Services] [Coinsurance] [Tier [1]]	[0% - 100% [until the [Preventive Medicine Services] [Tier [1]] Out-of-Pocket Limits are satisfied; [then Tier [2];] [100% thereafter.]]	[0% - 100% [until the [Preventive Medicine Services] [Tier [1]] Out-of-Pocket Limits are satisfied; [then Tier [2];] [100% thereafter.]]	[0% - 100% [until the [Preventive Medicine Services] [Tier [1]] Out-of-Pocket Limits are satisfied; [then Tier [2];] [100% thereafter.]]
[Tier [1]] [Preventive Medicine Services] [Out-of-Pocket Limit] [each [Calendar Year] [Benefit Period] [Time Period] [Plan Year]] [Individual] [Per Covered Child] [Family]	[$0 - $25,000 / Not applicable] [$0 - $75,000 / Not applicable]	[$0 - $25,000 / Not applicable] [$0 - $75,000 / Not applicable]	[$0 - $25,000 / an additional $0 - $10,000] [$0 - $75,000 / an additional $0 - $30,000]
[Preventive Medicine Services] [Coinsurance] [Tier [2]]	[0% - 100% [until the [Preventive Medicine Services] [Tier [2]] Out-of-Pocket Limits are satisfied; [then Tier [X];] [100% thereafter.]]	[0% - 100% [until the [Preventive Medicine Services] [Tier [2]] Out-of-Pocket Limits are satisfied; [then Tier [X];] [100% thereafter.]]	[0% - 100% [until the [I Preventive Medicine Services] [Tier [2]] Out-of-Pocket Limits are satisfied; [then Tier [X];] [100% thereafter.]]

[Tier [2]] [Preventive Medicine Services] [Out-of-Pocket Limit] [each [Calendar Year] [Benefit Period] [Time Period] [Plan Year]] [Individual] [Per Covered Child]	[$0 - $25,000 / Not applicable]	[$0 - $25,000 / Not applicable]	[$0 - $25,000 / an additional $0 - $10,000]
[Family]	[$0 - $75,000 / Not applicable]	[$0 - $75,000 / Not applicable]	[$0 - $75,000 / an additional $0 - $30,000]
[Preventive Medicine Services] [Coinsurance] [Tier [X]]	[0% - 100% [until the [Preventive Medicine Services] [Tier [X]] Out-of-Pocket Limits are satisfied;] [then Tier [X + [1]];] [100% thereafter.]]	[0% - 100% [until the [Preventive Medicine Services] [Tier [X]] Out-of-Pocket Limits are satisfied;] [then Tier [X + [1]];] [100% thereafter.]]	[0% - 100% [until the [Preventive Medicine Services] [Tier [X]] Out-of-Pocket Limits are satisfied;] [then Tier [X + [1]];] [100% thereafter.]]
[Tier [X]] [Preventive Medicine Services] [Out-of-Pocket Limit][each [Calendar Year] [Benefit Period] [Time Period] [Plan Year]] [Individual] [Per Covered Child]	[$0 - $25,000 / Not applicable]	[$0 - $25,000 / Not applicable]	[$0 - $25,000 / an additional $0 - $10,000]
[Family]	[$0 - $75,000 / Not applicable]	[$0 - $75,000 / Not applicable]	[$0 - $75,000 / an additional $0 - $30,000]
[[Preventive Medicine Services] Out-of-Pocket Limits] [Individual] [Per Covered Child]	[$XXX]	[$XXX]	[$XXX]
[Family]	[$XXX]	[$XXX]	[$XXX]
[Benefits for Preventive Medicine Services are payable at [0-100%] [with a [$10-$100] Copayment] when a Designated Specialty Service Provider is used. If a Designated Specialty Service Provider is not used, [Covered Charges will be [paid at the [Non-][Participating] [or] [applicable] Coinsurance] [reduced by [$1 - $3,000] [1% - 50%]][limited to [$XXX] per [Calendar] [Plan] Year] [per Covered Person] [after the Covered Person has paid any applicable Copayment, Deductible or other fees.] [These limitations will apply to all treatment rendered by a provider that is not designated as a [Designated Specialty Service Provider] regardless of whether the provider is a [Network Provider,] [Participating Provider,] [or] [Select Participating Provider].]			

BEN: 035.001.001.GE

Children's Preventive Health Care Services
Preventive Medicine Services shall include children's preventive health care services which shall include 20 visits at approximately the following ages: birth, 2 weeks, 2 months, 4 months, 6 months, 9 months, 12 months, 15 months, 18 months, 2 years, 3 years, 4 years, 5 years, 6 years, 8 years, 10 years, 12 years, 14 years, 16 years, and 18 years.
[Subject to [Plan] [and] [Outpatient] [Integrated] [Per Cause] Deductible] and [Plan] [and] [Outpatient] Coinsurance [unless otherwise specified]] Deductible and Coinsurance will be waived for child immunizations.
[Benefit for Preventive Medicine Services are limited to a Maximum [Lifetime] [Calendar Year] [Plan Year] [Monthly] [Daily] [Benefit Period] [Benefit] of [$500] [per [Covered Person] [covered child] [Family].] The maximum will not apply to child immunizations.
[Preventive Medicine Services Benefit Waiting Period is [12] [months].] The waiting period will not apply to child immunizations.

BEN: 036.001.AR

[**Loss or Impairment of Speech or Hearing**]:

[All services, supplies and treatments apply to the [Outpatient] [and] [Calendar Year] [and] [Plan Year] [and] [Benefit Period] [Per Cause] Maximum Benefit]			
[Subject to [Plan] [and] [Outpatient] [Integrated] [Per Cause] Deductible] and [Plan] [and] [Outpatient] Coinsurance [unless otherwise specified]]			
	[Select] Participating Provider Benefits]	**[Participating Provider Benefits / Network Provider Benefits]**	**[Non-[Select] Participating Provider Benefits/ Non-Participating Provider Benefits/ Non-Network Provider Benefits]**
[[Loss or Impairment of Speech or Hearing] Maximum [Lifetime] [Calendar Year] [Plan Year] [Benefit Period] [Per Cause] [Monthly] [Daily] Benefit]	[$XXX] [per Covered Person] [Per Covered Child]	[$XXX] [per Covered Person] [Per Covered Child]	[$XXX] [per Covered Person] [Per Covered Child]
[Loss or Impairment of Speech or Hearing] Deductible] [Individual] [Per Covered Child] [Integrated] [Family]	[$XXX] [$XXX]	[$XXX] [$XXX]	[$XXX] [$XXX]
[[Non-Participating] [Non-Network] Provider Deductible is in addition to the [Participating] [Network] Provider Deductible.]			
[Once [[2] or more Covered Persons have collectively met] the maximum Family Deductible [has been met], no additional Deductible will be taken during the [Calendar Year] [Plan Year] [Benefit Period] [Time Period].]			
[Loss or Impairment of Speech or Hearing] [Coinsurance] [Tier [1]]	[0% - 100% [until the [Loss or Impairment of Speech or Hearing]] [Tier [1]] Out-of-Pocket Limits are satisfied; [then Tier [2];] [100% thereafter.]]	[0% - 100% [until the [Loss or Impairment of Speech or Hearing]] [Tier [1]] Out-of-Pocket Limits are satisfied; [then Tier [2];] [100% thereafter.]]	[0% - 100% [until the [Loss or Impairment of Speech or Hearing] [Tier [1]] Out-of-Pocket Limits are satisfied; [then Tier [2];] [100% thereafter.]]
[Tier [1]] [Loss or Impairment of Speech or Hearing] [Out-of-Pocket Limit] [each [Calendar Year] [Benefit Period] [Time Period] [Plan Year]] [Individual] [Per Covered Child] [Family]	[$0 - $25,000 / Not applicable] [$0 - $75,000 / Not applicable]	[$0 - $25,000 / Not applicable] [$0 - $75,000 / Not applicable]	[$0 - $25,000 / an additional $0 - $10,000] [$0 - $75,000 / an additional $0 - $30,000]
Loss or Impairment of Speech or Hearing] [Tier [2]]	[0% - 100% [until the [Loss or Impairment of Speech or Hearing] [Tier [2]] Out-of-Pocket Limits are satisfied; [then Tier [X];] [100% thereafter.]]	[0% - 100% [until the [Loss or Impairment of Speech or Hearing] [Tier [2]] Out-of-Pocket Limits are satisfied; [then Tier [X];] [100% thereafter.]]	[0% - 100% [until the [I Loss or Impairment of Speech or Hearing] [Tier [2]] Out-of-Pocket Limits are satisfied; [then Tier [X];] [100% thereafter.]]

[Tier [2]] [P Loss or Impairment of Speech or Hearing]] [Out-of-Pocket Limit] [each [Calendar Year] [Benefit Period] [Time Period] [Plan Year]] [Individual] [Per Covered Child]	[$0 - $25,000 / Not applicable]	[$0 - $25,000 / Not applicable]	[$0 - $25,000 / an additional $0 - $10,000]
[Family]	[$0 - $75,000 / Not applicable]	[$0 - $75,000 / Not applicable]	[$0 - $75,000 / an additional $0 - $30,000]
[Loss or Impairment of Speech or Hearing]] [Coinsurance] [Tier [X]]	[0% - 100% [until the [Loss or Impairment of Speech or Hearing] [Tier [X]] Out-of-Pocket Limits are satisfied;] [then Tier [X + [1]];] [100% thereafter.]]	[0% - 100% [until the [Loss or Impairment of Speech or Hearing] [Tier [X]] Out-of-Pocket Limits are satisfied;] [then Tier [X + [1]];] [100% thereafter.]]	[0% - 100% [until the [Loss or Impairment of Speech or Hearing] [Tier [X]] Out-of-Pocket Limits are satisfied;] [then Tier [X + [1]];] [100% thereafter.]]
[Tier [X]] [Loss or Impairment of Speech or Hearing]] [Out-of-Pocket Limit][each [Calendar Year] [Benefit Period] [Time Period] [Plan Year]] [Individual] [Per Covered Child]	[$0 - $25,000 / Not applicable]	[$0 - $25,000 / Not applicable]	[$0 - $25,000 / an additional $0 - $10,000]
[Family]	[$0 - $75,000 / Not applicable]	[$0 - $75,000 / Not applicable]	[$0 - $75,000 / an additional $0 - $30,000]
[[Loss or Impairment of Speech or Hearing]] Out-of-Pocket Limits] [Individual] [Per Covered Child]	[$XXX]	[$XXX]	[$XXX]
[Family]	[$XXX]	[$XXX]	[$XXX]
[Benefits for Loss or Impairment of Speech or Hearing Services are payable at [0-100%] [with a [$10-$100] Copayment] when a Designated Specialty Service Provider is used. If a Designated Specialty Service Provider is not used, [Covered Charges will be [paid at the [Non-][Participating] [or] [applicable] Coinsurance] [reduced by [$1 - $3,000] [1% - 50%]][limited to [$XXX] per [Calendar] [Plan] Year] [per Covered Person] [after the Covered Person has paid any applicable Copayment, Deductible or other fees.] [These limitations will apply to all treatment rendered by a provider that is not designated as a [Designated Specialty Service Provider] regardless of whether the provider is a [Network Provider,] [Participating Provider,] [or] [Select Participating Provider].]of whether the provider is a [Network Provider,] [Participating Provider,] [or] [Select Participating Provider			

BEN: 037.001.AR

Medical Foods:			
[All services, supplies and treatments apply to the [Outpatient] [and] [Calendar Year] [and] [Plan Year] [and] [Benefit Period] [Per Cause] [and] [Monthly] [and] [Daily] Maximum Benefit]			
[Subject to [Plan] [and] [Outpatient] [Integrated] Deductible and [Plan] [and] [Outpatient] Coinsurance [unless otherwise specified]]			
No benefits are available for the first {$2,400] of Covered Charges incurred by a Covered Person in a calendar year.			
	[Select Participating	**[Participating**	**[Non-[Select]**

	Provider Benefits]	**Provider Benefits / Network Provider Benefits]**	**Participating Provider Benefits/ Non-Participating Provider Benefits/ Non-Network Provider Benefits]**
[Medical Foods] [Coinsurance]	[0% - 100% [until the Out-of-Pocket Limits are satisfied;] [100% thereafter.]]	[0% - 100% [until the Out-of-Pocket Limits are satisfied;] [100% thereafter.]]	[0% - 100% [until the Out-of-Pocket Limits are satisfied;] [100% thereafter.]]
[Benefits for Family Planning Services are payable at [0-100%] [with a [$10-$100] Copayment] when a Designated Specialty Service Provider is used. If a Designated Specialty Service Provider is not used, [Covered Charges will be [paid at the [Non-][Participating] [or] [applicable] Coinsurance] [reduced by [$1 - $3,000] [1% - 50%]][limited to [$XXX] per [Calendar] [Plan] Year] [per Covered Person] [after the Covered Person has paid any applicable Copayment, Deductible or other fees.] [These limitations will apply to all treatment rendered by a provider that is not designated as a Designated Specialty Service Provider regardless of whether the provider is a [Network Provider,] [Participating Provider,] [or] [Select Participating Provider].]			

BEN: 038.001.AR

[**Accident Medical Expense** [**Reduced Plan Deductible**] **Benefit**:]			
[All services, supplies and treatments apply to the [Plan] [and] [Outpatient] [and] [Calendar Year] [Plan Year] [Benefit Period] [Per Cause] Maximum Benefit]			
[Subject to [Plan] [and] [Inpatient] [and] [Outpatient] [Integrated] [Per Cause] Deductible] and [Plan] [and] [Inpatient] [and] [Outpatient] Coinsurance [unless otherwise specified].]			
[We will pay up to [$XXX] per [Calendar Year] [Plan Year] [Benefit Period] [Per Cause][Accidental Injury] [Injury] for Covered Charges Incurred due to an Accidental Injury. After payment of this amount, Covered Charges will be subject to the [Plan] [and] [Inpatient] [and] [Outpatient] [Integrated] [Per Cause] Deductible] and [Plan] [and] [Inpatient] [and] [Outpatient] Coinsurance.]			
[Covered charges must be Incurred within [90] days of the Accident] [Injury]. [Covered Charges in excess of the Accident Medical Expense Benefit or rendered after the 90-day period will be subject to all the terms, limits and conditions of the plan.]			
[Accident Medical Expense is subject to the Accident Medical Expense Deductible [and Coinsurance] then Covered Charges are paid at [100%] up to [$XX]. Covered Charges are then subject to the [Plan] [and][Outpatient] [and] [Inpatient] [Integrated] [Per Cause] Deductible] and [Plan] [and][Outpatient] [and] [Inpatient]Coinsurance.]]			
[Your [Plan] [Individual] [Integrated] [Family] [Per Cause] Deductible] will be reduced by [$XXX] for Covered Charges Incurred due to an [Accidental Injury] [Injury],] [then subject to [Plan] [and][Outpatient] [and] [Inpatient] [Coinsurance]]			
[Accident Medical Expense Benefit Waiting Period is [XX days]]			
[Not Covered]			
	[Primary Care Physician / [Select] Participating Provider [Benefits]]	**[Participating Provider [Benefits] / Network Provider [Benefits]]**	**[Non-[Select] Participating Provider [Benefits]/ Non-Participating Provider [Benefits]/ Non-Network Provider [Benefits]]**
[Accident Medical Expense Benefit] Maximum [Lifetime] [Calendar Year] [Plan Year] [Benefit Period] [Per Cause] [Monthly] [Daily] Benefit]	[$XXX] [per Covered Person] [Per Covered Child]	[$XXX] [per Covered Person] [Per Covered Child]	[$XXX] [per Covered Person] [Per Covered Child]
[Accident Medical Expense Benefit Deductible] [Individual] [Per Covered Child] [Integrated] [Family]	 [$XXX] [$XXX]	 [$XXX] [$XXX]	 [$XXX] [$XXX]

[The [Accident Medical Expense Benefit Deductible] does [not] apply to the Plan Deductible or Total Out-of-Pocket Limits.]			
[[Non-Participating] [Non-network] Provider Deductible is in addition to the [Participating] [Network] Provider Deductible.]			
[Once [[2] or more Covered Persons have collectively met] the maximum Family Deductible [has been met], no additional Deductible will be taken during the [Calendar Year] [Plan Year] [Benefit Period] [Time Period].]			
[Accident Medical Expense Benefit] [Coinsurance] [Tier [1]]	[0% - 100% [until the [Accident Medical Expense] [Tier [1]] Out-of-Pocket Limits are satisfied; [then Tier [2];] [100% thereafter.]]	[0% - 100% [until the [Accident Medical Expense] [Tier [1]] Out-of-Pocket Limits are satisfied; [then Tier [2];] [100% thereafter.]]	[0% - 100% [until the [Accident Medical Expense] [Tier [1]] Out-of-Pocket Limits are satisfied; [then Tier [2];] [100% thereafter.]]
[Tier [1]] [Accident Medical Expense Benefit] Out-of-Pocket Limit [each [Calendar Year] [Benefit Period] [Time Period] [Plan Year]] [Individual] [Per Covered Child] [Family]	[$0 - $25,000 / Not applicable] [$0 - $75,000 / Not applicable]	[$0 - $25,000 / Not applicable] [$0 - $75,000 / Not applicable]	[$0 - $25,000 / an additional $0 - $10,000] [$0 - $75,000 / an additional $0 - $30,000]
[Accident Medical Expense Benefit] [Coinsurance] [Tier [2]]	[0% - 100% [until the [Accident Medical Expense] [Tier [2]] Out-of-Pocket Limits are satisfied; [then Tier [X];] [100% thereafter.]]	[0% - 100% [until the [Accident Medical Expense] [Tier [2]] Out-of-Pocket Limits are satisfied; [then Tier [X];] [100% thereafter.]]	[0% - 100% [until the [Accident Medical Expense] [Tier [2]] Out-of-Pocket Limits are satisfied; [then Tier [X];] [100% thereafter.]]
[Tier [2]] [Accident Medical Expense Benefit] Out-of-Pocket Limit [each [Calendar Year] [Benefit Period] [Time Period] [Plan Year]] [Individual] [Per Covered Child] [Family]	[$0 - $25,000 / Not applicable] [$0 - $75,000 / Not applicable]	[$0 - $25,000 / Not applicable] [$0 - $75,000 / Not applicable]	[$0 - $25,000 / an additional $0 - $10,000] [$0 - $75,000 / an additional $0 - $30,000]
[Accident Medical Expense Benefit] [Coinsurance] [Tier [X]]	[0% - 100% [until the [Accident Medical Expense] [Tier [X]] Out-of-Pocket Limits are satisfied;] [then Tier [X + [1]];] [100% thereafter.]]	[0% - 100% [until the [Accident Medical Expense] [Tier [X]] Out-of-Pocket Limits are satisfied;] [then Tier [X + [1]];] [100% thereafter.]]	[0% - 100% [until the [Accident Medical Expense] [Tier [X]] Out-of-Pocket Limits are satisfied;] [then Tier [X + [1]];] [100% thereafter.]]

[Tier [X]] [Accident Medical Expense Benefit] Out-of-Pocket Limit [each [Calendar Year] [Benefit Period] [Time Period] [Plan Year]]			
[Individual] [Per Covered Child]	[$0 - $25,000 / Not applicable]	[$0 - $25,000 / Not applicable]	[$0 - $25,000 / an additional $0 - $10,000]
[Family]	[$0 - $75,000 / Not applicable]	[$0 - $75,000 / Not applicable]	[$0 - $75,000 / an additional $0 - $30,000]
[[Accident Medical Expense] Out-of-Pocket Limits]			
[Individual] [Per Covered Child]	[$XXX]	[$XXX]	[$XXX]
[Family]	[$XXX]	[$XXX]	[$XXX]

BEN: 040.001.001.GE

[[**Diagnostic Imaging Services**] [**and**] [**Laboratory Services**]:]			
[All services, supplies and treatments apply to the [Inpatient][Outpatient] [Calendar Year] [Plan Year] [Benefit Period] [Per Cause] Maximum Benefit]			
[Subject to [Plan] [Outpatient][Inpatient] [Integrated] Deductible and [Plan] [Outpatient] [Inpatient]Coinsurance [unless otherwise specified]]			
[[Plan] [Integrated] [Per Cause] Deductible] [and Co-insurance] will be waived for the first [$XXX] of Covered Services] [per] [Covered Person] [covered child] [Family] [per [Calendar Year] [Plan Year] [Benefit Period] [Per Cause]] [after a [12 month] [365 day] Benefit Waiting Period].]			
[[Diagnostic Imaging Services] [and] [Laboratory Services] Benefit Waiting Period is [[12] [months] [[365] days].]			
[Limited to [Diagnostic Imaging Services] [and] [Laboratory Services] associated with an Inpatient Stay when Covered Charges are Incurred within [14 days] of admission.]			
[Includes [1] screening mammography exam per Benefit Period for a covered female age [35] or over.] [The maximum benefit for a mammography screening is [$50 - $500].]			
[Diagnostic Imaging Services] [and] [Laboratory Services] are limited to a [Calendar Year] [Plan Year] [Benefit Period] [Per Cause] [Monthly] [Daily] Maximum of [$XXX] [per] [Covered Person] [covered child] [Family]]			
[Not Covered]			
	[[Select] Participating Provider [Benefits]]	**[Participating Provider [Benefits] / Network Provider [Benefits]]**	**[Non-[Select] Participating Provider [Benefits]/ Non-Participating Provider [Benefits]/ Non-Network Provider [Benefits]]**
[[Diagnostic Imaging Services] Maximum Benefit]	[$XXX] [[per] [Covered Person][Covered Child].]	[$XXX] [[per] [Covered Person][Covered Child].]	[$XXX] [[per] [Covered Person][Covered Child].]
[[Diagnostic Imaging Services] Maximum Benefit] [due to an [Accidental Injury] [Injury] [or] [underlying Sickness]]	[$XXX][[per] [Covered Person][Covered Child].]	[$XXX] [[per] [Covered Person][Covered Child].]	[$XXX] [[per] [Covered Person][Covered Child].]
[[Diagnostic Imaging Services] [and] [Laboratory Services] [Per Cause]			

Deductible]] [Individual] [Integrated] [Family]	[$XXX] [$XXX]	[$XXX] [$XXX]	[$XXX] [$XXX]
[The [Diagnostic Imaging Services] [and] [Laboratory Services] Deductible] does [not] apply to the [Plan][Outpatient][Inpatient][Integrated] [Per Cause] Deductible] or Total Out-of-Pocket Limits.]			
[[Non-Participating] [Non-Network] [Retail Health Clinic] Provider Deductible is in addition to the [Participating] [Network] Provider Deductible.]			
[Once [[2] or more Covered Persons have collectively met] the maximum Family Deductible [has been met]], no additional Deductible will be taken during the [Calendar Year] [Plan Year] [Benefit Period] [Time Period].]			
[[Diagnostic Imaging Services] [and] [Laboratory Services]] [Coinsurance] [Tier [1]]	[0% - 100% [until the [[[Diagnostic Imaging Services] [and] [Laboratory Services]] [Tier [1]] Out-of-Pocket Limits are satisfied; [then Tier [2];] [100% thereafter.]]	[0% - 100% [until the [[[Diagnostic Imaging Services] [and] [Laboratory Services]] [Tier [1]] Out-of-Pocket Limits are satisfied; [then Tier [2];] [100% thereafter.]]	[0% - 100% [until the [[Diagnostic Imaging Services] [and] [Laboratory Services] [Tier [1]] Out-of-Pocket Limits are satisfied; [then Tier [2];] [100% thereafter.]]
[Tier [1]] [[Diagnostic Imaging Services] [and] [Laboratory Services]][Out-of-Pocket Limit] [each [Calendar Year] [Benefit Period] [Time Period] [Plan Year]] [Individual] [Family]	[$0 - $25,000 / Not applicable] [$0 - $75,000 / Not applicable]	[$0 - $25,000 / Not applicable] [$0 - $75,000 / Not applicable]	[$0 - $25,000 / an additional $0 - $10,000] [$0 - $75,000 / an additional $0 - $30,000]
[[Diagnostic Imaging Services] [and] [Laboratory Services] [Coinsurance]] [Tier [2]]	[0% - 100% [until the [[[Diagnostic Imaging Services] [and] [Laboratory Services] [Tier [2]] Out-of-Pocket Limits are satisfied; [then Tier [X];] [100% thereafter.]]	[0% - 100% [until the [[Diagnostic Imaging Services] [and] [Laboratory Services] [Tier [2]] Out-of-Pocket Limits are satisfied; [then Tier [X];] [100% thereafter.]]	[0% - 100% [until the [[Diagnostic Imaging Services] [and] [Laboratory Services] [Tier [2]] Out-of-Pocket Limits are satisfied; [then Tier [X];] [100% thereafter.]]
[Tier [2]] [[Diagnostic Imaging Services] [and] [Laboratory Services]] [Out-of-Pocket Limit][each [Calendar Year] [Benefit Period] [Time Period] [Plan Year]] [Individual] [Family]	[$0 - $25,000 / Not applicable] [$0 - $75,000 / Not applicable]	[$0 - $25,000 / Not applicable] [$0 - $75,000 / Not applicable]	[$0 - $25,000 / an additional $0 - $10,000] [$0 - $75,000 / an additional $0 - $30,000]

[[Diagnostic Imaging Services] [and] [Laboratory Services] [Coinsurance]] [Tier [X]]	[0% - 100% [until the [[Diagnostic Imaging Services] [and] [Laboratory Services]] [Tier [X]] Out-of-Pocket Limits are satisfied;] [then Tier [X + [1]];] [100% thereafter.]]	[0% - 100% [until the [[Diagnostic Imaging Services] [and] [Laboratory Services] [Tier [X]] Out-of-Pocket Limits are satisfied;] [then Tier [X + [1]];] [100% thereafter.]]	[0% - 100% [until the [[Diagnostic Imaging Services] [and] [Laboratory Services] [Tier [X]] Out-of-Pocket Limits are satisfied;] [then Tier [X + [1]];] [100% thereafter.]]
[Tier [X]] [[Diagnostic Imaging Services] [and] [Laboratory Services]][Out-of-Pocket Limit][each [Calendar Year] [Benefit Period] [Time Period] [Plan Year]] [Individual] [Family]	[$0 - $25,000 / Not applicable] [$0 - $75,000 / Not applicable]	[$0 - $25,000 / Not applicable] [$0 - $75,000 / Not applicable]	[$0 - $25,000 / an additional $0 - $10,000] [$0 - $75,000 / an additional $0 - $30,000]
[[[Diagnostic Imaging Services] [and] [Laboratory Services] [Out-of-Pocket Limits]] [Individual] [Integrated] [Family]	[$XXX] [$XXX]	[$XXX] [$XXX]	[$XXX] [$XXX]
[Benefits for [Diagnostic Imaging Services] [and] [Laboratory Services] are payable at [0-100%] [with a [$10-$100] Copayment] when a Designated Specialty Service Provider is used. If a Designated Specialty Service Provider is not used, [Covered Charges will be [paid at the [Non-][Participating] [or] [applicable] Coinsurance] [reduced by [$1 - $3,000] [1% - 50%]] [limited to [$XXX] per [Calendar] [Plan] Year] [per Covered Person] [after the Covered Person has paid any applicable Copayment, Deductible or other fees.]] [These limitations will apply to all treatment rendered by a provider that is not designated as a [Designated Specialty Service Provider] regardless of whether the provider is a [Network Provider,] [Participating Provider,] [or] [Select Participating Provider].]			

BEN: 045.001.001.GE

[**Outpatient Physical Medicine Services**:]
[All services, supplies and treatments apply to the [Outpatient] [Calendar Year] [Plan Year] [Benefit Period] [Per Cause] Maximum Benefit]
[Subject to [Outpatient] [Plan] [Integrated] [Per Cause] Deductible] and [Outpatient] [Plan] Coinsurance [unless otherwise specified]]
[Benefits are limited to an Outpatient Physical Medicine Services Maximum [Lifetime] [Calendar Year] [Plan Year] [Monthly] [Daily] [Benefit Period] [Per Cause] Benefit of [$XXX] [per] [Covered Person] [covered child] [Family] [unless due to an [Accidental Injury] [Injury] [or] [underlying Sickness] [then We will pay up to a [$XXX] Maximum [Lifetime] [Calendar Year] [Plan Year] [Benefit Period] [Per Cause] [Monthly] [Daily] Benefit] [per] [Covered Person] [covered child] [Family]]
[We will pay [up to] an Outpatient Physical Medicine Services Maximum of [$XXX] [per] [Covered Person] [covered child] [Family] [per [day] [episode]][unless due to an [Accidental Injury] [Injury] [or] [underlying Sickness] [then We will pay up to [$XXX] [per [day] [episode]]
[Benefits for Outpatient Physical Medicine Services are limited to [1-20] visits each [Calendar Year] [Plan Year] [Benefit Period] [Per Cause] per Covered Person with a maximum payment of [$25 - $200] per visit]
[Chiropractic Coverage is] [Adjustments and manipulations are] limited to a Maximum [Lifetime] [Calendar Year][Plan Year] [Monthly] [Daily] [Benefit Period] [Per Cause] Benefit of [$XXX] [per] [Covered Person][Family]]
[Outpatient Physical Medicine Services Benefits Waiting Period is [[12] months]][[365] days]

[Not Covered]			
	[[Select] Participating Provider [Benefits]]	**[Participating Provider [Benefits] / Network Provider [Benefits]]**	**[Non-[Select] Participating Provider [Benefits]/ Non-Participating Provider [Benefits]/ Non-Network Provider [Benefits]]**
[[Outpatient Physical Medicine Services] Maximum Benefit]	[$XXX] [per] [Covered Person] [covered child] [Family] [per [day] [episode]]	[$XXX] [per] [Covered Person] [covered child] [Family] [per [day] [episode]]	[$XXX] [per] [Covered Person] [covered child] [Family] [per [day] [episode]]
[[Outpatient Physical Medicine Services] [due to an [Accidental Injury] [Injury] [or] [underlying Sickness]]	[$XXX] [per] [Covered Person] [covered child] [Family] [per [day] [episode]]	[$XXX] [per] [Covered Person] [covered child] [Family] [per [day] [episode]]	[$XXX] [per] [Covered Person] [covered child] [Family] [per [day] [episode]]
[Outpatient Physical Medicine Services [Per Cause] Deductible]] [Individual]	[$XXX]	[$XXX]	[$XXX]
[Integrated] [Family]	[$XXX]	[$XXX]	[$XXX]
[The [Outpatient Physical Medicine Services Deductible] does [not] apply to the Plan Deductible or Total Out-of-Pocket Limits.]			
[[Non-Participating] [Non-network] Provider Deductible is in addition to the [Participating] [Network] Provider Deductible.]			
[Once [[2] or more Covered Persons have collectively met] the maximum Family Deductible [has been met], no additional Deductible will be taken during the [Calendar Year] [Plan Year] [Benefit Period] [Time Period].]			
[Outpatient Physical Medicine Services] [Copayment]	[None / $XXX per Outpatient Physical Medicine Services]	[None / $XXX per Outpatient Physical Medicine Services]	[None / $XXX per Outpatient Physical Medicine Services]
[Outpatient Physical Medicine Services] [Coinsurance] [Tier [1]]	[0% - 100% [until the [Outpatient Physical Medicine Services] [Tier [1]] Out-of-Pocket Limits are satisfied; [then Tier [2];] [100% thereafter.]]	[0% - 100% [until the [Outpatient Physical Medicine Services] [Tier [1]] Out-of-Pocket Limits are satisfied; [then Tier [2];] [100% thereafter.]]	[0% - 100% [until the [Outpatient Physical Medicine Services] [Tier [1]] Out-of-Pocket Limits are satisfied; [then Tier [2];] [100% thereafter.]]
[Tier [1]] [Outpatient Physical Medicine Services] [Out-of-Pocket Limit] [each [Calendar Year] [Benefit Period] [Time Period] [Plan Year]] [Individual]	[$0 - $25,000 / Not applicable]	[$0 - $25,000 / Not applicable]	[$0 - $25,000 / an additional $0 - $10,000]
[Family]	[$0 - $75,000 / Not applicable]	[$0 - $75,000 / Not applicable]	[$0 - $75,000 / an additional $0 - $30,000]

[Outpatient Physical Medicine Services] [Coinsurance] [Tier [2]]	[0% - 100% [until the [Outpatient Physical Medicine Services] [Tier [2]] Out-of-Pocket Limits are satisfied; [then Tier [X];] [100% thereafter.]]	[0% - 100% [until the [Outpatient Physical Medicine Services] [Tier [2]] Out-of-Pocket Limits are satisfied; [then Tier [X];] [100% thereafter.]]	[0% - 100% [until the [Outpatient Physical Medicine Services] [Tier [2]] Out-of-Pocket Limits are satisfied; [then Tier [X];] [100% thereafter.]]
[Tier [2]] [Outpatient Physical Medicine Services] [Out-of-Pocket Limit][each [Calendar Year] [Benefit Period] [Time Period] [Plan Year]] [Individual]	[$0 - $25,000 / Not applicable]	[$0 - $25,000 / Not applicable]	[$0 - $25,000 / an additional $0 - $10,000]
[Family]	[$0 - $75,000 / Not applicable]	[$0 - $75,000 / Not applicable]	[$0 - $75,000 / an additional $0 - $30,000]
[Outpatient Physical Medicine Services] [Coinsurance] [Tier [X]]	[0% - 100% [until the [Outpatient Physical Medicine Services] [Tier [X]] Out-of-Pocket Limits are satisfied;] [then Tier [X + [1]];] [100% thereafter.]]	[0% - 100% [until the [Outpatient Physical Medicine Services] [Tier [X]] Out-of-Pocket Limits are satisfied;] [then Tier [X + [1]];] [100% thereafter.]]	[0% - 100% [until the [Outpatient Physical Medicine Services] [Tier [X]] Out-of-Pocket Limits are satisfied;] [then Tier [X + [1]];] [100% thereafter.]]
[Tier [X]] [Outpatient Physical Medicine Services] [Out-of-Pocket Limit][each [Calendar Year] [Benefit Period] [Time Period] [Plan Year]] [Individual]	[$0 - $25,000 / Not applicable]	[$0 - $25,000 / Not applicable]	[$0 - $25,000 / an additional $0 - $10,000]
[Family]	[$0 - $75,000 / Not applicable]	[$0 - $75,000 / Not applicable]	[$0 - $75,000 / an additional $0 - $30,000]
[[Outpatient Physical Medicine Services] [Out-of-Pocket Limits]] [Individual]	[$XXX]	[$XXX]	[$XXX]
[Integrated] [Family]	[$XXX]	[$XXX]	[$XXX]
[Benefits for Outpatient Physical Medicine Services are payable at [0-100%] [with a [$10-$100] Copayment] when a Designated Specialty Service Provider is used. If a Designated Specialty Service Provider is not used, [Covered Charges will be [paid at the [Non-][Participating] [or] [applicable] Coinsurance] [reduced by [$1 - $3,000] [1% - 50%]][limited to [$XXX] per [Calendar] [Plan] Year] [per Covered Person] [after the Covered Person has paid any applicable Copayment, Deductible or other fees.] [These limitations will apply to all treatment rendered by a provider that is not designated as a [Designated Specialty Service Provider] regardless of whether the provider is a [Network Provider,] [Participating Provider,] [or] [Select Participating Provider].]			

BEN: 050.001.001.GE

[**Outpatient Alternative Medicine Services**:]
[All services, supplies and treatments apply to the [Outpatient] [and] [Calendar Year] [and] [Plan Year] [Benefit

Period] [Per Cause] Maximum Benefit]			
[Subject to [Plan] [and] [Outpatient] [Integrated] [Per Cause] Deductible] and [Plan] [and] [Outpatient] Coinsurance [unless otherwise specified]]			
[Benefits for Outpatient Alternative Medicine Services are limited to a Maximum [Lifetime] [Calendar Year] [Plan Year] [Benefit Period] [Per Cause] [Monthly] [Daily] Benefit of [$20 - $5,000]]			
[Benefits for Outpatient Alternative Medicine Services are limited to a Maximum Benefit of [[$XX] for each visit[up to [XX] visits]] [up to [$XXX] each [Calendar] [Plan] Year] [Benefit Period] [per Covered Person]]			
[Outpatient Alternative Medicine Services Benefit Waiting Period is [[6] [months] [[180] days].]			
[Not Covered]			
	[[Select] Participating Provider [Benefits]]	**[Participating Provider [Benefits] / Network Provider [Benefits]]**	**[Non-[Select] Participating Provider [Benefits]/ Non-Participating Provider [Benefits]/ Non-Network Provider [Benefits]]**
[Outpatient Alternative Medicine Services]] Maximum [Lifetime] [Calendar Year] [Plan Year] [Benefit Period] [Per Cause] [Monthly] [Daily] Benefit]	[$XXX] [per Covered Person]	[$XXX] [per Covered Person]	[$XXX] [per Covered Person]
[Outpatient Alternative Medicine Services Deductible] [Individual] [Integrated] [Family]	 [$XXX] [$XXX]	 [$XXX] [$XXX]	 [$XXX] [$XXX]
[The [Outpatient Alternative Medicine Services Deductible] does [not] apply to the Plan Deductible or Total Out-of-Pocket Limits.]			
[[Non-Participating] [Non-network] Provider Deductible is in addition to the [Participating] [Network] Provider Deductible.]			
[Once [[2] or more Covered Persons have collectively met] the maximum Family Deductible [[has been met], no additional Deductible will be taken during the [Calendar Year] [Plan Year] [Benefit Period] [Time Period].]			
[Access] [Fee]	[None / $XXX per Alternative Medical Care Service]	[None / $XXX per Alternative Medical Care Service]	[None / $XXX per Alternative Medical Care Service]
[Copayment]	[None / $XXX per Alternative Medical Care Service]	[None / $XXX per Alternative Medical Care Service]	[None / $XXX per Alternative Medical Care Service]
[[Outpatient Alternative Medicine Services] [Coinsurance] [Tier [1]]	[0% - 100% [until the [Outpatient Alternative Medicine Services] [Tier [1]] Out-of-Pocket Limits are satisfied; [then Tier [2];] [100% thereafter.]]	[0% - 100% [until the [Outpatient Alternative Medicine Services] [Tier [1]] Out-of-Pocket Limits are satisfied; [then Tier [2];] [100% thereafter.]]	[0% - 100% [until the [Outpatient Alternative Medicine Services] [Tier [1]] Out-of-Pocket Limits are satisfied; [then Tier [2];] [100% thereafter.]]
[Tier [1]] [[Outpatient Alternative Medicine Services]Out-of-Pocket Limit [each [Calendar Year] [Benefit Period] [Time Period] [Plan Year]] [Individual]	[$0 - $25,000 / Not applicable]	[$0 - $25,000 / Not applicable]	[$0 - $25,000 / an additional $0 - $10,000]

[Family]	[$0 - $75,000 / Not applicable]	[$0 - $75,000 / Not applicable]	[$0 - $75,000 / an additional $0 - $30,000]
[[Outpatient Alternative Medicine Services] [Coinsurance] [Tier [2]]	[0% - 100% [until the [Outpatient Alternative Medicine Services] [Tier [2]] Out-of-Pocket Limits are satisfied; [then Tier [X];] [100% thereafter.]]	[0% - 100% [until the [Outpatient Alternative Medicine Services] [Tier [2]] Out-of-Pocket Limits are satisfied; [then Tier [X];] [100% thereafter.]]	[0% - 100% [until the [Outpatient Alternative Medicine Services] [Tier [2]] Out-of-Pocket Limits are satisfied; [then Tier [X];] [100% thereafter.]]
[Tier [2]] [[Outpatient Alternative Medicine Services]Out-of-Pocket Limit [each [Calendar Year] [Benefit Period] [Time Period] [Plan Year]] [Individual]	[$0 - $25,000 / Not applicable]	[$0 - $25,000 / Not applicable]	[$0 - $25,000 / an additional $0 - $10,000]
[Family]	[$0 - $75,000 / Not applicable]	[$0 - $75,000 / Not applicable]	[$0 - $75,000 / an additional $0 - $30,000]
[[Outpatient Alternative Medicine Services] [Coinsurance] [Tier [X]]	[0% - 100% [until the [Outpatient Alternative Medicine Services] [Tier [X]] Out-of-Pocket Limits are satisfied;] [then Tier [X + [1]];] [100% thereafter.]]	[0% - 100% [until the [Outpatient Alternative Medicine Services] [Tier [X]] Out-of-Pocket Limits are satisfied;] [then Tier [X + [1]];] [100% thereafter.]]	[0% - 100% [until the [Outpatient Alternative Medicine Services] [Tier [X]] Out-of-Pocket Limits are satisfied;] [then Tier [X + [1]];] [100% thereafter.]]
[Tier [X]] [[Outpatient Alternative Medicine Services]Out-of-Pocket Limit [each [Calendar Year] [Benefit Period] [Time Period] [Plan Year]] [Individual]	[$0 - $25,000 / Not applicable]	[$0 - $25,000 / Not applicable]	[$0 - $25,000 / an additional $0 - $10,000]
[Family]	[$0 - $75,000 / Not applicable]	[$0 - $75,000 / Not applicable]	[$0 - $75,000 / an additional $0 - $30,000]
[[Outpatient Alternative Medicine Services] [Out-of-Pocket Limits]] [Individual]	[$XXX]	[$XXX]	[$XXX]
[Family]	[$XXX]	[$XXX]	[$XXX]
[Benefits for [Outpatient Alternative Medicine Services] are payable at [0-100%] [with a [$10-$100] Copayment] when a [Designated Specialty Service Provider] is used. If a [Designated Specialty Service Provider] is not used, [Covered Charges will be [paid at the [Non-][Participating] [or] [applicable] Coinsurance] [reduced by [$1 - $3,000] [1% -			

50%]][limited to [$XXX] per [Calendar] [Plan] Year] [per Covered Person] [after the Covered Person has paid any applicable Copayment, Deductible or other fees.] [These limitations will apply to all treatment rendered by a provider that is not designated as a [Designated Specialty Service Provider] regardless of whether the provider is a [Network Provider,] [Participating Provider,] [or] [Select Participating Provider].]

BEN: 055.001.001.GE

[**Durable Medical Equipment and Personal Medical Equipment**:]

[All services, supplies and treatments apply to the [Outpatient] [Calendar Year] [Plan Year] [Benefit Period] [Per Cause] Maximum Benefit]]

[Subject to [Plan] [Outpatient] [Integrated] Deductible and [Plan] [Outpatient] Coinsurance [unless otherwise specified]]

[[Durable Medical Equipment] [and] [Personal Medical Equipment] Benefits are limited to a [Lifetime][Calendar Year][Plan Year] [Benefit Period] [Per Cause] [Monthly] [Daily] Maximum of [$XXX] [per] [Covered Person][Covered Child].]

[Wheelchairs apply to the [Outpatient] [Calendar Year] [Plan Year] [Benefit Period] [Per Cause] Maximum Benefit]]

[Wheelchairs will be subject to [Plan] [and] [Outpatient] [Integrated] [Per Cause] Deductible and [Plan] [and] [Outpatient] Coinsurance [unless otherwise specified]]

[Not Covered]

	[[Select] Participating Provider [Benefits]]	**[Participating Provider [Benefits] / Network Provider [Benefits]]**	**[Non-[Select] Participating Provider [Benefits]/ Non-Participating Provider [Benefits]/ Non-Network Provider [Benefits]]**
[[Durable Medical Equipment and Personal Medical Equipment] Maximum Benefit]	[$XXX] [[per] [Covered Person][Covered Child].]	[$XXX] [per] [Covered Person][Covered Child].]	[$XXX] [per] [Covered Person][Covered Child].]
[[Durable Medical Equipment and Personal Medical Equipment] Maximum Benefit] [due to an [Accidental Injury] [Injury] [or] [underlying Sickness]]	[$XXX] [per] [Covered Person][Covered Child].]	[$XXX] [per] [Covered Person][Covered Child].]	[$XXX] [per] [Covered Person][Covered Child].]
[Durable Medical Equipment and Personal Medical Equipment [Per Cause] Deductible] [Individual] [Integrated] [Family]	 [$XXX] [$XXX]	 [$XXX] [$XXX]	 [$XXX] [$XXX]
[The [Durable Medical Equipment and Personal Medical Equipment Deductible] does [not] apply to the Plan Deductible or Total Out-of-Pocket Limits.]			
[[Non-Participating] [Non-Network] Provider Deductible is in addition to the [Participating] [Network] Provider Deductible.]			
[Once [[2] or more Covered Persons have collectively met] the maximum Family Deductible has been met], no additional Deductible will be taken during the [Calendar Year] [Plan Year] [Benefit Period] [Time Period].]			
[Personal Medical Equipment]	[$[XXXX] Maximum [Lifetime] [Calendar Year] [Plan Year] [Monthly] Benefit	[$[XXXX] Maximum [Lifetime] [Calendar Year] [Plan Year] [Monthly] Benefit	[$[XXXX] Maximum [Lifetime] [Calendar Year] [Plan Year] [Monthly] Benefit
[Initial] [Permanent] [Temporary] [Basic] [Artificial] [Limb] [or] [Eye]	[$[XXXX] Maximum [Lifetime] [Calendar Year] [Plan Year]	[$[XXXX] Maximum [Lifetime] [Calendar Year] [Plan Year]	[$[XXXX] Maximum [Lifetime] [Calendar Year] [Plan Year]

	[Monthly] Benefit	[Monthly] Benefit	[Monthly] Benefit
[Durable Medical Equipment]	[$[XXXX] Maximum [Lifetime] [Calendar Year] [Plan Year] [Monthly] Benefit	[$[XXXX] Maximum [Lifetime] [Calendar Year] [Plan Year] [Monthly] Benefit	[$[XXXX] Maximum [Lifetime] [Calendar Year] [Plan Year] [Monthly] Benefit
[Durable Medical Equipment and Personal Medical Equipment] [Coinsurance] [Tier [1]]	[0% - 100% [until the [Durable Medical Equipment and Personal Medical Equipment] [Tier [1]] Out-of-Pocket Limits are satisfied; [then Tier [2];] [100% thereafter.]]	[0% - 100% [until the [Durable Medical Equipment and Personal Medical Equipment] [Tier [1]] Out-of-Pocket Limits are satisfied; [then Tier [2];] [100% thereafter.]]	[0% - 100% [until the [Durable Medical Equipment and Personal Medical Equipment] [Tier [1]] Out-of-Pocket Limits are satisfied; [then Tier [2];] [100% thereafter.]]
[Tier [1]] [Durable Medical Equipment and Personal Medical Equipment] [Out-of-Pocket Limit][each [Calendar Year] [Benefit Period] [Time Period] [Plan Year]] [Individual] [Family]	[$0 - $25,000 / Not applicable] [$0 - $75,000 / Not applicable]	[$0 - $25,000 / Not applicable] [$0 - $75,000 / Not applicable]	[$0 - $25,000 / an additional $0 - $10,000] [$0 - $75,000 / an additional $0 - $30,000]
[Durable Medical Equipment and Personal Medical Equipment] [Coinsurance] [Tier [2]]	[0% - 100% [until the [Durable Medical Equipment and Personal Medical Equipment] [Tier [2]] Out-of-Pocket Limits are satisfied; [then Tier [X];] [100% thereafter.]]	[0% - 100% [until the [Durable Medical Equipment and Personal Medical Equipment] [Tier [2]] Out-of-Pocket Limits are satisfied; [then Tier [X];] [100% thereafter.]]	[0% - 100% [until the [Durable Medical Equipment and Personal Medical Equipment] [Tier [2]] Out-of-Pocket Limits are satisfied; [then Tier [X];] [100% thereafter.]]
[Tier [2]] [Durable Medical Equipment and Personal Medical Equipment] [Out-of-Pocket Limit] [each [Calendar Year] [Benefit Period] [Time Period] [Plan Year]] [Individual] [Family]	[$0 - $25,000 / Not applicable] [$0 - $75,000 / Not applicable]	[$0 - $25,000 / Not applicable] [$0 - $75,000 / Not applicable]	[$0 - $25,000 / an additional $0 - $10,000] [$0 - $75,000 / an additional $0 - $30,000]
[Durable Medical Equipment and Personal Medical Equipment] [Coinsurance] [Tier [X]]	[0% - 100% [until the [Durable Medical Equipment and Personal Medical Equipment] [Tier [X]] Out-of-Pocket Limits	[0% - 100% [until the [Durable Medical Equipment and Personal Medical Equipment] [Tier [X]] Out-of-Pocket Limits	[0% - 100% [until the [Durable Medical Equipment and Personal Medical Equipment] [Tier [X]] Out-of-Pocket Limits are satisfied;]

	are satisfied;] [then Tier [X + [1]];] [100% thereafter.]]	are satisfied;] [then Tier [X + [1]];] [100% thereafter.]]	[then Tier [X + [1]];] [100% thereafter.]]
[Tier [X]] [Durable Medical Equipment and Personal Medical Equipment] [Out-of-Pocket Limit] [each [Calendar Year] [Benefit Period] [Time Period] [Plan Year]]			
[Individual]	[$0 - $25,000 / Not applicable]	[$0 - $25,000 / Not applicable]	[$0 - $25,000 / an additional $0 - $10,000]
[Family]	[$0 - $75,000 / Not applicable]	[$0 - $75,000 / Not applicable]	[$0 - $75,000 / an additional $0 - $30,000]
[[Durable Medical Equipment and Personal Medical Equipment] Out-of-Pocket Limits]			
[Individual]	[$XXX]	[$XXX]	[$XXX]
[Family]	[$XXX]	[$XXX]	[$XXX]
[[Benefits for [Durable Medical Equipment and Personal Medical Equipment] are payable at [0-100%] [with a [$10-$100] Copayment] when a [Designated Specialty Service Provider] is used. If a Designated Specialty Service Provider is not used, [Covered Charges will be [paid at the [Non-][Participating] [or] [applicable] Coinsurance] [reduced by [$1 - $3,000] [1% - 50%]] [limited to [$XXX] per [Calendar] [Plan] Year] [per Covered Person] [after the Covered Person has paid any applicable Copayment, Deductible or other fees.] [These limitations will apply to all treatment rendered by a provider that is not designated as a Designated Specialty Service Provider] regardless of whether the provider is a [Network Provider,] [Participating Provider,] [or] [Select Participating Provider].]			

BEN: 060.001.001.GE

[**Maternity Care Services**:]			
[All services, supplies and treatments apply to the [Inpatient] [and] [Outpatient] [and] [Calendar Year] [Plan Year] [Benefit Period] [Per Cause] Maximum Benefit]			
[Subject to [Plan] [and] [Inpatient] [and] [Outpatient] [Integrated] Deductible and [Plan] [and] [Inpatient] [and] [Outpatient] Coinsurance [unless otherwise specified] [and any other plan provisions in the Benefit Summary].]			
[Benefits are limited to a Maximum [Lifetime] [Calendar Year] [Plan Year] [Monthly] [Daily] [Benefit Period] [Per Cause] Benefit of [$XXX] [per Covered Person]]			
[[Maternity Care Services] Benefit Waiting Period is [[12] months] [[30-365] days]]			
[Benefits will be reduced by [50%] if conception occurs during the [Benefit Waiting Period][first Calendar Year of the policy]]			
[Not Covered]			
	[[Select] Participating Provider [Benefits]]	**[Participating Provider [Benefits] / Network Provider [Benefits]]**	**[Non-[Select] Participating Provider [Benefits]/ Non-Participating Provider [Benefits]/ Non-Network Provider [Benefits]]**
[[Maternity Care Services] Maximum [Lifetime] [Calendar Year] [Plan Year] [Benefit Period] [Per Cause]	[$XXX] [per Covered Person]	[$XXX] [per Covered Person]	[$XXX] [per Covered Person]

[Monthly] [Daily] Benefit]			
[[Maternity Care Services] Maximum [Lifetime] [Calendar Year] [Plan Year] [Benefit Period] [Per Cause] [Monthly] [Daily] Benefit] [due to an [Accidental Injury] [Injury] [or] [underlying Sickness]]	[$XXX] [per Covered Person]	[$XXX] [per Covered Person]	[$XXX] [per Covered Person]
[Maternity Care Services Deductible] [Individual] [Integrated] [Family]	[$XXX] [$XXX]	[$XXX] [$XXX]	[$XXX] [$XXX]
[Maternity Care Services Deductible][if conception occurs after the Benefit Waiting Period expires] [Individual]	[$XXX] [Subject to plan Deductible and Coinsurance]	[$XXX] [Subject to plan Deductible and Coinsurance]	[$XXX] [Subject to plan Deductible and Coinsurance]
[Maternity Care Services Deductible] if conception occurs before the Benefit Waiting Period expires] [Individual]	[$XXX] [Subject to plan Deductible and Coinsurance]	[$XXX] [Subject to plan Deductible and Coinsurance]	[$XXX] [Subject to plan Deductible and Coinsurance]
[The [Maternity Care Services Deductible] does [not] apply to the Plan Deductible or Total Out-of-Pocket Limits.]			
[[Non-Participating] [Non-network] Provider Deductible is in addition to the [Participating] [Network] Provider Deductible.]			
[Once [[2] or more Covered Persons have collectively met] the maximum Family Deductible [has been met], no additional Deductible will be taken during the [Calendar Year] [Plan Year] [Benefit Period] [Time Period].]			
[Maternity Care Services] [Coinsurance] [Tier [1]]	[0% - 100% [until the [Maternity Care Services] [Tier [1]] Out-of-Pocket Limits are satisfied; [then Tier [2];] [100% thereafter.]]	[0% - 100% [until the [Maternity Care Services] [Tier [1]] Out-of-Pocket Limits are satisfied; [then Tier [2];] [100% thereafter.]]	[0% - 100% [until the [Maternity Care Services] [Tier [1]] Out-of-Pocket Limits are satisfied; [then Tier [2];] [100% thereafter.]]
[Tier [1]] [Maternity Care Services] [Out-of-Pocket Limit][each [Calendar Year] [Benefit Period] [Time Period] [Plan Year]] [Individual] [Family]	[$0 - $25,000 / Not applicable] [$0 - $75,000 / Not applicable]	[$0 - $25,000 / Not applicable] [$0 - $75,000 / Not applicable]	[$0 - $25,000 / an additional $0 - $10,000] [$0 - $75,000 / an additional $0 - $30,000]
[Maternity Care Services] [Coinsurance] [Tier [2]]	[0% - 100% [until the [Maternity Care Services] [Tier [2]] Out-of-Pocket Limits are satisfied; [then Tier [X];] [100% thereafter.]]	[0% - 100% [until the [Maternity Care Services] [Tier [2]] Out-of-Pocket Limits are satisfied; [then Tier [X];] [100% thereafter.]]	[0% - 100% [until the [Maternity Care Services] [Tier [2]] Out-of-Pocket Limits are satisfied; [then Tier [X];] [100% thereafter.]]

[Tier [2]] [Maternity Care Services] [Out-of-Pocket Limit] [each [Calendar Year] [Benefit Period] [Time Period] [Plan Year]] [Individual] [Family]	[$0 - $25,000 / Not applicable] [$0 - $75,000 / Not applicable]	[$0 - $25,000 / Not applicable] [$0 - $75,000 / Not applicable]	[$0 - $25,000 / an additional $0 - $10,000] [$0 - $75,000 / an additional $0 - $30,000]
[Maternity Care Services] [Coinsurance] [Tier [X]]	[0% - 100% [until the [Maternity Care Services] [Tier [X]] Out-of-Pocket Limits are satisfied;] [then Tier [X + [1]];] [100% thereafter.]]	[0% - 100% [until the [Maternity Care Services y] [Tier [X]] Out-of-Pocket Limits are satisfied;] [then Tier [X + [1]];] [100% thereafter.]]	[0% - 100% [until the [Maternity Care Services] [Tier [X]] Out-of-Pocket Limits are satisfied;] [then Tier [X + [1]];] [100% thereafter.]]
[Tier [X]] [Maternity Care Services] [Out-of-Pocket Limit] [each [Calendar Year] [Benefit Period] [Time Period] [Plan Year]] [Individual] [Family]	[$0 - $25,000 / Not applicable] [$0 - $75,000 / Not applicable]	[$0 - $25,000 / Not applicable] [$0 - $75,000 / Not applicable]	[$0 - $25,000 / an additional $0 - $10,000] [$0 - $75,000 / an additional $0 - $30,000]
[[Maternity Care Services] [Out-of-Pocket Limits]] [Individual] [Family]	[$XXX] [$XXX]	[$XXX] [$XXX]	[$XXX] [$XXX]

BEN: 065.001.001.GE

[**Complications of Pregnancy**:]
[All services, supplies and treatments apply to the [Inpatient] [and] [Outpatient] [Calendar Year] [Plan Year] [Benefit Period] [Per Cause] Maximum Benefit]
[Subject to [Plan] [Inpatient] [Outpatient] [Integrated] [Per Cause] Deductible] and [Plan] [Inpatient] [Outpatient] Coinsurance [unless otherwise specified]]
[Benefits are limited to a Maximum [Lifetime] [Calendar Year] [Plan Year] [Monthly] [Daily] [Benefit Period] [Per Cause] Benefit of [$XXX] [per] [Covered Person] [Family]]
[Not Covered]

BEN: 070.001.GE

[**Infertility Services**:]
[All services, supplies and treatments apply to the [Outpatient] [and] [Calendar Year] [and] [Plan Year] [and] [Benefit Period] [Per Cause] [and] [Monthly] [and] [Daily] Maximum Benefit]
[Subject to [Plan] [and] [Outpatient] [Integrated] [Per Cause] Deductible] and [Plan] [and] [Outpatient] Coinsurance [unless otherwise specified]]

[Benefits for Infertility Services are limited to a Maximum [Lifetime] [Calendar Year] [Plan Year] [Monthly] [Daily] [Benefit Period] [Per Cause] Benefit of [$XXX] [per Covered Person]]

[[Infertility Services] Benefit Waiting Period is [[12] months]] [[365] days]]

[Not Covered]

	[[Select] Participating Provider [Benefits]]	**[Participating Provider [Benefits] / Network Provider [Benefits]]**	**[Non-[Select] Participating Provider [Benefits]/ Non-participating Provider [Benefits]/ Non-network Provider [Benefits]]**
[[Infertility Services] Maximum [Lifetime] [Calendar Year] [Plan Year] [Benefit Period] [Per Cause] [Monthly] [Daily] Benefit]	[$XXX] [per Covered Person]	[$XXX] [per Covered Person]	[$XXX] [per Covered Person]
[[Infertility Services]l Maximum [Lifetime] [Calendar Year] [Plan Year] [Benefit Period] [Per Cause] [Monthly] [Daily] Benefit] [due to an [Accidental Injury] [or] [underlying Sickness]]	[$XXX] [per Covered Person]	[$XXX] [per Covered Person]	[$XXX] [per Covered Person]

[Benefits for Infertility Services are payable at [0-100%] [with a [$10-$100] copayment] when a Designated Specialty Service Provider is used. If a Designated Specialty Service Provider is not used, [Covered Charges will be [paid at the [Non-][Participating] [or] [applicable] Coinsurance] [reduced by [$1 - $3,000] [1% - 50%]][limited to [$XXX] per [Calendar] [Plan] Year] [per Covered Person] [after the Covered Person has paid any applicable Copayment, Deductible or other fees.] [These limitations will apply to all treatment rendered by a provider that is not designated as a Designated Specialty Service Provider regardless of whether the provider is a [Network Provider,] [Participating Provider,] [or] [Select Participating Provider].]

BEN: 075.001.001.GE

[**Health Care Practitioner Services**:]

[Subject to [Plan] [Inpatient] [Outpatient] [Integrated] [Per Cause] Deductible] and [Plan] [Inpatient] [Outpatient] Coinsurance [and any other [Plan] [Inpatient] [or] [Outpatient] provision in the Benefit Summary] [unless otherwise specified].]

[Benefits for Covered Charges rendered by an Anesthesiologist are limited to a [Calendar Year] [Plan Year] [Benefit Period] Maximum of [$XXX] for Inpatient services and [$XXX] for Outpatient Services.]

BEN: 080.001.GE

[**Professional Ground** [**or Air**] **Ambulance Services**:]

[All services, supplies and treatments apply to the [Outpatient] [Calendar Year] [Plan Year] [Benefit Period] [Per Cause] Maximum Benefit]

[Benefits are limited to a[n] [Professional Ground] [or] [Air] Ambulance Services Maximum [Lifetime] [Calendar Year] [Plan Year] [Monthly] [Daily] [Benefit Period] [Per Cause] Benefit of [$XXX] [per] [limited to] [[one] trip] [per Sickness or Injury] [per Covered Person].]

[Subject to [Plan] [Outpatient] [Integrated] [Per Cause] Deductible] and [Plan] [Outpatient] Coinsurance [unless otherwise specified]]

[Not Covered]

	[[Select] Participating Provider [Benefits]]	**[Participating Provider [Benefits] / Network Provider [Benefits]]**	**[Non-[Select] Participating Provider [Benefits]/ Non-Participating Provider [Benefits]/ Non-Network Provider [Benefits]]**

[Professional Ground [or Air] Ambulance Services] [Lifetime] [Calendar Year] [Plan Year] [Benefit Period] [Per Cause] Maximum Benefit [per Covered Person]	[$XXX] [and] [or] [limited to] [1] [trip]	[$XXX] [and] [or] [limited to] [1] [trip]	[$XXX] [and] [or] [limited to] [1] [trip]
[Professional Ground [or Air] Ambulance Services] [Coinsurance]	[0% - 100% [until the Out-of-Pocket Limits are satisfied;] [100% thereafter.]]	[0% - 100% [until the Out-of-Pocket Limits are satisfied;] [100% thereafter.]]	[0% - 100% [until the Out-of-Pocket Limits are satisfied;] [100% thereafter.]]

BEN: 085.001.GE

[**Home Health Care Services**:]			
[All services, supplies and treatments apply to the [Outpatient] [Calendar Year] [Plan Year] [Benefit Period] [Per Cause] Maximum Benefit]			
[Subject to [Outpatient] [Plan] [Integrated] [Per Cause] Deductible] and [Outpatient] [Plan] Coinsurance [unless otherwise specified]]			
[Benefits are limited to a Maximum [Calendar Year] [Plan Year] [Benefit Period] [Per Cause] [Monthly] Benefit of [20 - 200 hours] [or] [10-100 visits][per Covered Person]]			
[Benefits are limited to a Maximum [Lifetime] Benefit of [$XXX] [per] [Covered Person] [Family]]			
[Not Covered]			
	[[Select] Participating Provider [Benefits]]	**[Participating Provider [Benefits] / Network Provider [Benefits]]**	**[Non-[Select] Participating Provider [Benefits]/ Non-Participating Provider [Benefits]/ Non-Network Provider [Benefits]]**
[[Home Health Care Services] Maximum Benefit]	[$XXX]	[$XXX]	[$XXX]
[[Home Health Care Services] [due to an [Accidental Injury] [Injury] [or] [underlying Sickness]	[$XXX]	[$XXX]	[$XXX]
[[Home Health Care Services [Per Cause] Deductible]] [Individual] [Integrated] [Family]	 [$XXX] [$XXX]	 [$XXX] [$XXX]	 [$XXX] [$XXX]
[The [Home Health Care Services Deductible] does [not] apply to the Plan Deductible or Total Out-of-Pocket Limits.]			
[[Non-Participating] [Non-network] Provider Deductible is in addition to the [Participating] [Network] Provider Deductible.]			
[Once [[2] or more Covered Persons have collectively met] the maximum Family Deductible [has been met], no additional Deductible will be taken during the [Calendar Year] [Plan Year] [Benefit Period] [Time Period].]			
[Home Health Care Services] [Coinsurance] [Tier [1]]	[0% - 100% [until the [Home Health Care Services] [Tier [1]] Out-of-Pocket Limits are satisfied; [then Tier [2];] [100% thereafter.]]	[0% - 100% [until the [Home Health Care Services] [Tier [1]] Out-of-Pocket Limits are satisfied; [then Tier [2];] [100% thereafter.]]	[0% - 100% [until the [Home Health Care Services] [Tier [1]] Out-of-Pocket Limits are satisfied; [then Tier [2];] [100% thereafter.]]

[Tier [1]] [Home Health Care Services] [Out-of-Pocket Limit] [each [Calendar Year] [Benefit Period] [Time Period] [Plan Year]]			
[Individual]	[$0 - $25,000 / Not applicable]	[$0 - $25,000 / Not applicable]	[$0 - $25,000 / an additional $0 - $10,000]
[Family]	[$0 - $75,000 / Not applicable]	[$0 - $75,000 / Not applicable]	[$0 - $75,000 / an additional $0 - $30,000]
[Home Health Care Services] [Coinsurance] [Tier [2]]	[0% - 100% [until the [Home Health Care Services] [Tier [2]] Out-of-Pocket Limits are satisfied; [then Tier [X];] [100% thereafter.]]	[0% - 100% [until the [Home Health Care Services] [Tier [2]] Out-of-Pocket Limits are satisfied; [then Tier [X];] [100% thereafter.]]	[0% - 100% [until the [Home Health Care Services] [Tier [2]] Out-of-Pocket Limits are satisfied; [then Tier [X];] [100% thereafter.]]
[Tier [2]] [Home Health Care Services][Out-of-Pocket Limit] [each [Calendar Year] [Benefit Period] [Time Period] [Plan Year]]			
[Individual]	[$0 - $25,000 / Not applicable]	[$0 - $25,000 / Not applicable]	[$0 - $25,000 / an additional $0 - $10,000]
[Family]	[$0 - $75,000 / Not applicable]	[$0 - $75,000 / Not applicable]	[$0 - $75,000 / an additional $0 - $30,000]
[Home Health Care Services] [Coinsurance] [Tier [X]]	[0% - 100% [until the [Home Health Care Services] [Tier [X]] Out-of-Pocket Limits are satisfied;] [then Tier [X + [1]];] [100% thereafter.]]	[0% - 100% [until the [Home Health Care Services] [Tier [X]] Out-of-Pocket Limits are satisfied;] [then Tier [X + [1]];] [100% thereafter.]]	[0% - 100% [until the [Home Health Care Services] [Tier [X]] Out-of-Pocket Limits are satisfied;] [then Tier [X + [1]];] [100% thereafter.]]
[Tier [X]] [Home Health Care Services] [Out-of-Pocket Limit] [each [Calendar Year] [Benefit Period] [Time Period] [Plan Year]]			
[Individual]	[$0 - $25,000 / Not applicable]	[$0 - $25,000 / Not applicable]	[$0 - $25,000 / an additional $0 - $10,000]
[Family]	[$0 - $75,000 / Not applicable]	[$0 - $75,000 / Not applicable]	[$0 - $75,000 / an additional $0 - $30,000]
[[Home Health Care Services] Out-of-Pocket Limits]			
[Individual]	[$XXX]	[$XXX]	[$XXX]
[Integrated] [Family]	[$XXX]	[$XXX]	[$XXX]

[Benefits for Home Health Care Services are payable at [0-100%] [with a [$10-$100] Copayment] when a Designated Specialty Service Provider is used. If a Designated Specialty Service Provider is not used, [Covered Charges will be [paid at the [Non-][Participating] [or] [applicable] Coinsurance] [reduced by [$1 - $3,000] [1% - 50%]][limited to [$XXX] per [Calendar] [Plan] Year] [per Covered Person] [after the Covered Person has paid any applicable Copayment, Deductible or other fees.] [These limitations will apply to all treatment rendered by a provider that is not designated as a Designated Specialty Service Provider regardless of whether the provider is a [Network Provider,] [Participating Provider,] [or] [Select Participating Provider].]

BEN: 090.001.001.GE

[**Hospice Care Services**:]

[All services, supplies and treatments apply to the [Outpatient][and] [Inpatient] [Calendar Year] [Plan Year] [Benefit Period] [Per Cause] Maximum Benefit]

[Subject to [Inpatient] [Outpatient] [Plan] [Integrated] [Per Cause] Deductible] and [Inpatient] [Outpatient] [Plan] Coinsurance [unless otherwise specified].]

[Benefits are limited to a Maximum [Calendar Year] [Plan Year] [Monthly] [Daily] [Benefit Period] [Per Cause] Benefit of [$XXX] [per] [Covered Person] [Family]]

[Benefits are limited to a Maximum [Lifetime] Benefit of [$XXX] [per] [Covered Person] [Family]]

[Hospice Care Services include [2] visits for counseling services and [1] visit for bereavement counseling after a Covered Person's death] [[per] [Covered Person] [Family]]

[Not Covered]

	[[Select] Participating Provider [Benefits]]	**[Participating Provider [Benefits] / Network Provider [Benefits]]**	**[Non-[Select] Participating Provider [Benefits]/ Non-Participating Provider [Benefits]/ Non-Network Provider [Benefits]]**
[[Hospice Care Services] Maximum Benefit]	[$XXX]	[$XXX]	[$XXX]
[[Hospice Care Services] Maximum Benefit] [due to an [Accidental Injury] [Injury] [or] [underlying Sickness]	[$XXX]	[$XXX]	[$XXX]
[Hospice Care Services Deductible] [Individual]	[$XXX]	[$XXX]	[$XXX]
[Integrated] [Family]	[$XXX]	[$XXX]	[$XXX]

[The [Hospice Care Services Deductible] does [not] apply to the Plan Deductible or Total Out-of-Pocket Limits]

[[Non-Participating] [Non-network] Provider Deductible is in addition to the [Participating] [Network] Provider Deductible]

[Once [[2] or more Covered Persons have collectively met] the maximum Family Deductible [has been met], no additional Deductible will be taken during the [Calendar Year] [Plan Year] [Benefit Period] [Time Period].]

[Hospice Care Services] [Coinsurance] [Tier [1]]	[0% - 100% [until the [Hospice Care Services] [Tier [1]] Out-of-Pocket Limits are satisfied; [then Tier [2];] [100% thereafter.]]	[0% - 100% [until the [Hospice Care Services] [Tier [1]] Out-of-Pocket Limits are satisfied; [then Tier [2];] [100% thereafter.]]	[0% - 100% [until the [Hospice Care Services] [Tier [1]] Out-of-Pocket Limits are satisfied; [then Tier [2];] [100% thereafter.]]
[Tier [1]] [Hospice Care Services] [Out-of-Pocket Limit] [each [Calendar Year] [Benefit Period] [Time Period] [Plan Year]] [Individual]	[$0 - $25,000 / Not	[$0 - $25,000 / Not	[$0 - $25,000 / an

	applicable]	applicable]	additional $0 - $10,000]
[Family]	[$0 - $75,000 / Not applicable]	[$0 - $75,000 / Not applicable]	[$0 - $75,000 / an additional $0 - $30,000]
[Hospice Care Services] [Coinsurance] [Tier [2]]	[0% - 100% [until the [Hospice Care Services] [Tier [2]] Out-of-Pocket Limits are satisfied; [then Tier [X];] [100% thereafter.]]	[0% - 100% [until the [Hospice Care Services] [Tier [2]] Out-of-Pocket Limits are satisfied; [then Tier [X];] [100% thereafter.]]	[0% - 100% [until the [Hospice Care Services] [Tier [2]] Out-of-Pocket Limits are satisfied; [then Tier [X];] [100% thereafter.]]
[Tier [2]] [Hospice Care Services] [Out-of-Pocket Limit] [each [Calendar Year] [Benefit Period] [Time Period] [Plan Year]]			
[Individual]	[$0 - $25,000 / Not applicable]	[$0 - $25,000 / Not applicable]	[$0 - $25,000 / an additional $0 - $10,000]
[Family]	[$0 - $75,000 / Not applicable]	[$0 - $75,000 / Not applicable]	[$0 - $75,000 / an additional $0 - $30,000]
[Hospice Care Services] [Coinsurance] [Tier [X]]	[0% - 100% [until the [Hospice Care Services] [Tier [X]] Out-of-Pocket Limits are satisfied;] [then Tier [X + [1]];] [100% thereafter.]]	[0% - 100% [until the [Hospice Care Services] [Tier [X]] Out-of-Pocket Limits are satisfied;] [then Tier [X + [1]];] [100% thereafter.]]	[0% - 100% [until the [Hospice Care Services] [Tier [X]] Out-of-Pocket Limits are satisfied;] [then Tier [X + [1]];] [100% thereafter.]]
[Tier [X]] [Hospice Care Services] [Out-of-Pocket Limit] [each [Calendar Year] [Benefit Period] [Time Period] [Plan Year]]			
[Individual]	[$0 - $25,000 / Not applicable]	[$0 - $25,000 / Not applicable]	[$0 - $25,000 / an additional $0 - $10,000]
[Family]	[$0 - $75,000 / Not applicable]	[$0 - $75,000 / Not applicable]	[$0 - $75,000 / an additional $0 - $30,000]
[[Hospice Care Services] Out-of-Pocket Limits]			
[Individual]	[$XXX]	[$XXX]	[$XXX]
[Integrated] [Family]	[$XXX]	[$XXX]	[$XXX]
[Benefits for Hospice Care Service are payable at [0-100%] [with a [$10-$100] Copayment] when a Designated Specialty Service Provider is used. If a Designated Specialty Service Provider is not used, [Covered Charges will be [paid at the [Non-][Participating] [or] [applicable] Coinsurance] [reduced by [$1 - $3,000] [1% - 50%]][limited to [$XXX] per [Calendar] [Plan] Year] [per Covered Person] [after the Covered Person has paid any applicable Copayment, Deductible or other fees.] [These limitations will apply to all treatment rendered by a provider that is not designated as a Designated Specialty Service Provider regardless of whether the provider is a [Network			

Provider,] [Participating Provider,] [or] [Select Participating Provider].]

BEN: 095.001.001.GE

[**Inpatient Rehabilitation Services**:]			
[All services, supplies and treatments apply to the [Inpatient] [and] [Calendar Year] [Plan Year] [Benefit Period] [Per Cause] Maximum Benefit]			
[Subject to [Plan] [Inpatient] [Integrated] [Per Cause] Deductible] and [Plan] [Inpatient] Coinsurance [unless otherwise specified]]			
[Benefits are limited to a Maximum [Lifetime] [Calendar Year] [Plan Year] [Benefit Period] [Per Cause] [Monthly] [Daily] Benefit of [$XXX] [or] [90 days] [per Covered Person] [whichever is less] [greater]]			
[Not Covered]			
	[[Select] Participating Provider [Benefits]]	**[Participating Provider [Benefits] / Network Provider [Benefits]]**	**[Non-[Select} Participating Provider [Benefits]/ Non-Participating Provider [Benefits]/ Non-Network Provider [Benefits]]**
[[Inpatient Rehabilitation Services] Maximum [Lifetime] [Calendar Year] [Plan Year] [Benefit Period] [Per Cause] [Monthly] [Daily] Benefit	[$XXX] [or] [90][days] [per Covered Person] [whichever is [less] [greater]]	[$XXX] [or] [90][days] [per Covered Person] [whichever is [less] [greater]]	[$XXX] [or] [90][days] [per Covered Person] [whichever is [less] [greater]]
[Inpatient Rehabilitation Services [Per Cause] Deductible] [Individual] [Integrated] [Family]	 [$XXX] [$XXX]	 [$XXX] [$XXX]	 [$XXX] [$XXX]
[The [Inpatient Rehabilitation Services Deductible] does [not] apply to the Plan Deductible or Total Out-of-Pocket Limits.]			
[[Non-Participating] [Non-network] Provider Deductible is in addition to the [Participating] [Network] Provider Deductible.]			
[Once [[2] or more Covered Persons have collectively met] the maximum Family Deductible [has been met], no additional Deductible will be taken during the [Calendar Year] [Plan Year] [Benefit Period] [Time Period].]			
[Inpatient Rehabilitation Services] [Coinsurance] [Tier [1]]	[0% - 100% [until the [Inpatient Rehabilitation Services] [Tier [1]] Out-of-Pocket Limits are satisfied; [then Tier [2];] [100% thereafter.]]	[0% - 100% [until the [Inpatient Rehabilitation Services] [Tier [1]] Out-of-Pocket Limits are satisfied; [then Tier [2];] [100% thereafter.]]	[0% - 100% [until the [Inpatient Rehabilitation Services] [Tier [1]] Out-of-Pocket Limits are satisfied; [then Tier [2];] [100% thereafter.]]
[Tier [1]] [Inpatient Rehabilitation Services] [Out-of-Pocket Limit] [each [Calendar Year] [Benefit Period] [Time Period] [Plan Year]] [Individual] [Family]	 [$0 - $25,000 / Not applicable] [$0 - $75,000 / Not applicable]	 [$0 - $25,000 / Not applicable] [$0 - $75,000 / Not applicable]	 [$0 - $25,000 / an additional $0 - $10,000] [$0 - $75,000 / an additional $0 - $30,000]

[Inpatient Rehabilitation Services] [Coinsurance] [Tier [2]]	[0% - 100% [until the [Inpatient Rehabilitation Services] [Tier [2]] Out-of-Pocket Limits are satisfied; [then Tier [X];] [100% thereafter.]]	[0% - 100% [until the [Inpatient Rehabilitation Services] [Tier [2]] Out-of-Pocket Limits are satisfied; [then Tier [X];] [100% thereafter.]]	[0% - 100% [until the [Inpatient Rehabilitation Services] [Tier [2]] Out-of-Pocket Limits are satisfied; [then Tier [X];] [100% thereafter.]]
[Tier [2]] [Inpatient Rehabilitation Services] [Out-of-Pocket Limit] [each [Calendar Year] [Benefit Period] [Time Period] [Plan Year]] [Individual] [Family]	[$0 - $25,000 / Not applicable] [$0 - $75,000 / Not applicable]	[$0 - $25,000 / Not applicable] [$0 - $75,000 / Not applicable]	[$0 - $25,000 / an additional $0 - $10,000] [$0 - $75,000 / an additional $0 - $30,000]
[Inpatient Rehabilitation Services] [Coinsurance] [Tier [X]]	[0% - 100% [until the [Inpatient Rehabilitation Services] [Tier [X]] Out-of-Pocket Limits are satisfied;] [then Tier [X + [1]];] [100% thereafter.]]	[0% - 100% [until the [Inpatient Rehabilitation Services] [Tier [X]] Out-of-Pocket Limits are satisfied;] [then Tier [X + [1]];] [100% thereafter.]]	[0% - 100% [until the [Inpatient Rehabilitation Services] [Tier [X]] Out-of-Pocket Limits are satisfied;] [then Tier [X + [1]];] [100% thereafter.]]
[Tier [X]] [Inpatient Rehabilitation Services] [Out-of-Pocket Limit] [each [Calendar Year] [Benefit Period] [Time Period] [Plan Year]] [Individual] [Family]	[$0 - $25,000 / Not applicable] [$0 - $75,000 / Not applicable]	[$0 - $25,000 / Not applicable] [$0 - $75,000 / Not applicable]	[$0 - $25,000 / an additional $0 - $10,000] [$0 - $75,000 / an additional $0 - $30,000]
[[Inpatient Rehabilitation Services] [Out-of-Pocket Limits]] [Individual] [Integrated] [Family]	[$XXX] [$XXX]	[$XXX] [$XXX]	[$XXX] [$XXX]
[Benefits for Inpatient Rehabilitation Services are payable at [0-100%] [with a [$10-$100] Copayment] when a Designated Specialty Service Provider is used. If a [Designated Specialty Service Provider] is not used, [Covered Charges will be [paid at the [Non-][Participating] [or] [applicable] Coinsurance] [reduced by [$1 - $3,000] [1% - 50%]][limited to [$XXX] per [Calendar] [Plan] Year] [per Covered Person] [after the Covered Person has paid any applicable Copayment, Deductible or other fees.] [These limitations will apply to all treatment rendered by a provider that is not designated as a Designated Specialty Service Provider regardless of whether the provider is a [Network Provider,] [Participating Provider,] [or] [Select Participating Provider].]			

BEN: 100.001.GE

[[**Subacute Rehabilitation Facility**] [**and/or**] [**Skilled Nursing Facility Care**]:]			
[All services, supplies and treatments apply to the [Outpatient] [and] [Inpatient] [Calendar Year] [Plan Year] [Benefit Period] [Per Cause] Maximum Benefit]			
[Subject to [Outpatient] [and] [Inpatient] [Calendar Year] [Plan Year] [Benefit Period] [Per Cause] [Plan] [Integrated] [Per Cause] Deductible] [and][Outpatient] [and] [Inpatient] [Calendar Year] [Plan Year] [Benefit Period] [Per Cause] [Plan] Coinsurance [unless otherwise specified]]			
[Benefits are limited to a Maximum [Lifetime] [Calendar Year] [Plan Year] [Benefit Period] [Per Cause] [Monthly] [Daily] Benefit of [$XXX] [or] [90 days] [per Covered Person] [whichever is [less] [greater].]			
[Benefits are limited to a Maximum of [$XXX] per day, up to [50] Days per [Calendar Year] [Plan Year] [Benefit Period] [Per Cause] [per Covered Person]]			
[Not Covered]			
	[[Select] Participating Provider [Benefits]]	**[Participating Provider [Benefits] / Network Provider [Benefits]]**	**[Non-[Select] Participating Provider [Benefits]/ Non-Participating Provider [Benefits]/ Non-Network Provider [Benefits]]**
[[Subacute Rehabilitation Facility and Skilled Nursing Facility Care] Maximum Benefit]	[$XXX]	[$XXX]	[$XXX]
[[Subacute Rehabilitation Facility and Skilled Nursing Facility Care] [due to an [Accidental Injury] [Injury] [or] [underlying Sickness]]	[$XXX]	[$XXX]	[$XXX]
[Subacute Rehabilitation Facility and Skilled Nursing Facility Care [Per Cause] Deductible] [Individual] [Integrated] [Family]	 [$XXX] [$XXX]	 [$XXX] [$XXX]	 [$XXX] [$XXX]
[The [Subacute Rehabilitation Facility and Skilled Nursing Facility Care Deductible] does [not] apply to the Plan Deductible or Total Out-of-Pocket Limits.]			
[[Non-Participating] [Non-network] Provider Deductible is in addition to the [Participating] [Network] Provider Deductible.]			
[Once [[2] or more Covered Persons have collectively met] the maximum Family Deductible [has been met], no additional Deductible will be taken during the [Calendar Year] [Plan Year] [Benefit Period] [Time Period].]			
[Subacute Rehabilitation Facility and Skilled Nursing Facility Care] [Coinsurance] [Tier [1]]	[0% - 100% [until the [Subacute Rehabilitation Facility and Skilled Nursing Facility Care] [Tier [1]] Out-of-Pocket Limits are satisfied; [then Tier [2];] [100% thereafter.]]	[0% - 100% [until the [Subacute Rehabilitation Facility and Skilled Nursing Facility Care] [Tier [1]] Out-of-Pocket Limits are satisfied; [then Tier [2];] [100% thereafter.]]	[0% - 100% [until the [Subacute Rehabilitation Facility and Skilled Nursing Facility Care] [Tier [1]] Out-of-Pocket Limits are satisfied; [then Tier [2];] [100% thereafter.]]
[Tier [1]] [Subacute Rehabilitation Facility and Skilled Nursing Facility Care] [Out-of-Pocket Limit] [each [Calendar Year] [Benefit Period] [Time Period] [Plan Year]] [Individual]	[$0 - $25,000 / Not applicable]	[$0 - $25,000 / Not applicable]	[$0 - $25,000 / an additional $0 - $10,000]

[Family]	[$0 - $75,000 / Not applicable]	[$0 - $75,000 / Not applicable]	[$0 - $75,000 / an additional $0 - $30,000]
[Subacute Rehabilitation Facility and Skilled Nursing Facility Care] [Coinsurance] [Tier [2]]	[0% - 100% [until the [Subacute Rehabilitation Facility and Skilled Nursing Facility Care] [Tier [2]] Out-of-Pocket Limits are satisfied; [then Tier [X];] [100% thereafter.]]	[0% - 100% [until the [Subacute Rehabilitation Facility and Skilled Nursing Facility Care] [Tier [2]] Out-of-Pocket Limits are satisfied; [then Tier [X];] [100% thereafter.]]	[0% - 100% [until the [Subacute Rehabilitation Facility and Skilled Nursing Facility Care] [Tier [2]] Out-of-Pocket Limits are satisfied; [then Tier [X];] [100% thereafter.]]
[Tier [2]] [Subacute Rehabilitation Facility and Skilled Nursing Facility Care] [Out-of-Pocket Limit] [each [Calendar Year] [Benefit Period] [Time Period] [Plan Year]] [Individual]	[$0 - $25,000 / Not applicable]	[$0 - $25,000 / Not applicable]	[$0 - $25,000 / an additional $0 - $10,000]
[Family]	[$0 - $75,000 / Not applicable]	[$0 - $75,000 / Not applicable]	[$0 - $75,000 / an additional $0 - $30,000]
[Subacute Rehabilitation Facility and Skilled Nursing Facility Care] [Coinsurance] [Tier [X]]	[0% - 100% [until the [Subacute Rehabilitation Facility and Skilled Nursing Facility Care] [Tier [X]] Out-of-Pocket Limits are satisfied;] [then Tier [X + [1]];] [100% thereafter.]]	[0% - 100% [until the [Subacute Rehabilitation Facility and Skilled Nursing Facility Care] [Tier [X]] Out-of-Pocket Limits are satisfied;] [then Tier [X + [1]];] [100% thereafter.]]	[0% - 100% [until the [Subacute Rehabilitation Facility and Skilled Nursing Facility Care] [Tier [X]] Out-of-Pocket Limits are satisfied;] [then Tier [X + [1]];] [100% thereafter.]]
[Tier [X]] [Subacute Rehabilitation Facility and Skilled Nursing Facility Care] [Out-of-Pocket Limit] [each [Calendar Year] [Benefit Period] [Time Period] [Plan Year]] [Individual]	[$0 - $25,000 / Not applicable]	[$0 - $25,000 / Not applicable]	[$0 - $25,000 / an additional $0 - $10,000]
[Family]	[$0 - $75,000 / Not applicable]	[$0 - $75,000 / Not applicable]	[$0 - $75,000 / an additional $0 - $30,000]
[[Subacute Rehabilitation Facility and Skilled Nursing Facility Care] [Out-of-Pocket Limits]] [Individual]	[$XXX]	[$XXX]	[$XXX]

[Family]	[$XXX]	[$XXX]	[$XXX]
[Benefits for Subacute Rehabilitation Facility and Skilled Nursing Facility Care are payable at [0-100%] [with a [$10-$100] Copayment] when a Designated Specialty Service Provider is used. If a Designated Specialty Service Provider is not used, [Covered Charges will be [paid at the [Non-][Participating] [or] [applicable] Coinsurance] [reduced by [$1 - $3,000] [1% - 50%]][limited to [$XXX] per [Calendar] [Plan] Year] [per Covered Person] [after the Covered Person has paid any applicable Copayment, Deductible or other fees.] [These limitations will apply to all treatment rendered by a provider that is not designated as a Designated Specialty Service Provider regardless of whether the provider is a [Network Provider,] [Participating Provider,] [or] [Select Participating Provider].]			

BEN: 105.001.GE

[**Family Planning Services**:]			
[All services, supplies and treatments apply to the [Outpatient] [and] [Calendar Year] [and] [Plan Year] [and] [Benefit Period] [Per Cause] [and] [Monthly] [and] [Daily] Maximum Benefit]			
[Subject to [Plan] [and] [Outpatient] [Integrated] Deductible and [Plan] [and] [Outpatient] Coinsurance [unless otherwise specified]]			
[Benefits for Family Planning Services are limited to a Maximum [Lifetime] [Calendar Year] [Plan Year] [Monthly] [Daily] [Benefit Period] [Per Cause] Benefit of [$XXX] [per Covered Person]]			
[[Family Planning Services] Benefit Waiting Period is [[12] months]] [[365] days]]			
[Not Covered]			
	[[Select] Participating Provider [Benefits]]	**[Participating Provider [Benefits] / Network Provider [Benefits]]**	**[Non-[Select] Participating Provider [Benefits]/ Non-Participating Provider [Benefits]/ Non-Network Provider [Benefits]]**
[[Family Planning Services] Maximum [Lifetime] [Calendar Year] [Plan Year] [Benefit Period] [Per Cause] [Monthly] [Daily] Benefit]	[$XXX] [per Covered Person]	[$XXX] [per Covered Person]	[$XXX] [per Covered Person]
[[Family Planning Services]l Maximum [Lifetime] [Calendar Year] [Plan Year] [Benefit Period] [Per Cause] [Monthly] [Daily] Benefit] [due to an [Accidental Injury] [Injury] [or] [underlying Sickness]	[$XXX] [per Covered Person]	[$XXX] [per Covered Person]	[$XXX] [per Covered Person]
[Benefits for Family Planning Services are payable at [0-100%] [with a [$10-$100] Copayment] when a Designated Specialty Service Provider is used. If a Designated Specialty Service Provider is not used, [Covered Charges will be [paid at the [Non-][Participating] [or] [applicable] Coinsurance] [reduced by [$1 - $3,000] [1% - 50%]][limited to [$XXX] per [Calendar] [Plan] Year] [per Covered Person] [after the Covered Person has paid any applicable Copayment, Deductible or other fees.] [These limitations will apply to all treatment rendered by a provider that is not designated as a Designated Specialty Service Provider regardless of whether the provider is a [Network Provider,] [Participating Provider,] [or] [Select Participating Provider].]			

BEN: 110.001.001.GE

[**Sterilization**:]
[All services, supplies and treatments apply to the [Outpatient] [Calendar Year] [Plan Year] [Benefit Period] [Per Cause] Maximum Benefit]
[Subject to [Plan] [Outpatient] [Integrated] [Per Cause] Deductible] and Coinsurance [unless otherwise specified].]
[Benefits for Sterilization Services are limited to a Maximum [Lifetime] [Calendar Year] [Plan Year] [Benefit Period] [Per Cause] [Monthly] [Daily] Benefit of [$250 - $2,500] [per Covered Person].]
[Sterilization Services Benefit Waiting Period is [[12] months] [[365] days]].

[Not Covered]			
	[[Select] Participating Provider [Benefits]]	**[Participating Provider [Benefits] / Network Provider [Benefits]]**	**[Non-[Select] Participating Provider [Benefits]/ Non-Participating Provider [Benefits]/ Non-Network Provider [Benefits]]**
[[Sterilization Services] Maximum [Lifetime] [Calendar Year] [Plan Year] [Benefit Period] [Per Cause] [Monthly] [Daily] Benefit]	[$XXX] [per Covered Person]	[$XXX] [per Covered Person]	[$XXX] [per Covered Person]
[Benefits for [Sterilization Services] are payable at [0-100%] [with a [$10-$100] Copayment] when a [Designated Specialty Service Provider] is used. If a [Designated Specialty Service Provider] is not used, [Covered Charges will be [paid at the [Non-][Participating] [or] [applicable] Coinsurance] [reduced by [$1 - $3,000] [1% - 50%]][limited to [$XXX] per [Calendar] [Plan] Year] [per Covered Person] [after the Covered Person has paid any applicable Copayment, Deductible or other fees.] [These limitations will apply to all treatment rendered by a provider that is not designated as a [Designated Specialty Service Provider] regardless of whether the provider is a [Network Provider,] [Participating Provider,] [or] [Select Participating Provider].]			

BEN: 115.001.001.GE

[**Temporomandibular Joint (TMJ) or Craniomandibular Joint (CMJ) Dysfunction Services**:]			
[All services, supplies and treatments apply to the [Outpatient] [Calendar Year] [Plan Year] [Benefit Period] [Per Cause] Maximum Benefit]			
[Subject to [Plan] [Outpatient] [Integrated] Deductible and [Plan] [Outpatient] Coinsurance [unless otherwise specified]]			
[Benefits for [surgical and] nonsurgical treatment are limited to a Maximum [Lifetime] [Calendar Year] [Plan Year] [Monthly] [Daily] [Benefit Period] [Per Cause] Benefit of [$XXX] [per] [Covered Person] [Family]]			
[Temporomandibular Joint (TMJ) or Craniomandibular Joint (CMJ) Dysfunction Services Benefit Waiting Period is [[12] months] [[365] days].]			
[Not Covered]			
	[[Select] Participating Provider [Benefits]]	**[Participating Provider [Benefits] / Network Provider [Benefits]]**	**[Non-[Select] Participating Provider [Benefits]/ Non-Participating Provider [Benefits]/ Non-Network Provider [Benefits]]**
[[Temporomandibular Joint (TMJ) or Craniomandibular Joint (CMJ) Dysfunction Services] [surgical and] non-surgical Maximum [Lifetime] [Calendar Year] [Plan Year] [Benefit Period] [Per Cause] [Monthly] [Daily] Benefit]	[$XXX] [per Covered Person] [per Family]	[$XXX] [per Covered Person] [per Family]	[$XXX] [per Covered Person] [per Family]
[[Temporomandibular Joint (TMJ) or Craniomandibular Joint (CMJ) Dysfunction Services] surgical and] non-surgical Maximum [Lifetime] [Calendar Year] [Plan Year] [Benefit Period] [Per Cause] [Monthly] [Daily] Benefit] [due to an [Accidental Injury] [Injury] [or] [underlying Sickness]	[$XXX] [per Covered Person] [per Family]	[$XXX] [per Covered Person] [per Family]	[$XXX] [per Covered Person] [per Family]
[Temporomandibular Joint (TMJ) or			

Craniomandibular Joint (CMJ) Dysfunction Services Deductible] [Individual] [Integrated] [Family]	[$XXX] [$XXX]	[$XXX] [$XXX]	[$XXX] [$XXX]
[The [Temporomandibular Joint (TMJ) or Craniomandibular Joint (CMJ) Dysfunction Services Deductible] does [not] apply to the [Plan][Outpatient] [Integrated] [Per Cause] Deductible] or Total Out-of-Pocket Limits.]			
[[Non-Participating] [Non-network] Provider Deductible is in addition to the [Participating] [Network] Provider Deductible.]			
[Once [[2] or more Covered Persons have collectively met] the maximum Family Deductible [has been met], no additional Deductible will be taken during the [Calendar Year] [Plan Year] [Benefit Period] [Time Period].]			
[Temporomandibular Joint (TMJ) or Craniomandibular Joint (CMJ) Dysfunction Services] [Coinsurance] [Tier [1]]	[0% - 100% [until the [Temporomandibular Joint (TMJ) or Craniomandibular Joint (CMJ) Dysfunction Services] [Tier [1]] Out-of-Pocket Limits are satisfied; [then Tier [2];] [100% thereafter.]]	[0% - 100% [until the [Temporomandibular Joint (TMJ) or Craniomandibular Joint (CMJ) Dysfunction Services] [Tier [1]] Out-of-Pocket Limits are satisfied; [then Tier [2];] [100% thereafter.]]	[0% - 100% [until the [Temporomandibular Joint (TMJ) or Craniomandibular Joint (CMJ) Dysfunction Services] [Tier [1]] Out-of-Pocket Limits are satisfied; [then Tier [2];] [100% thereafter.]]
[Tier [1]] [Temporomandibular Joint (TMJ) or Craniomandibular Joint (CMJ) Dysfunction Services] [Out-of-Pocket Limit] [each [Calendar Year] [Benefit Period] [Time Period] [Plan Year]] [Individual] [Family]	[$0 - $25,000 / Not applicable] [$0 - $75,000 / Not applicable]	[$0 - $25,000 / Not applicable] [$0 - $75,000 / Not applicable]	[$0 - $25,000 / an additional $0 - $10,000] [$0 - $75,000 / an additional $0 - $30,000]
[Temporomandibular Joint (TMJ) or Craniomandibular Joint (CMJ) Dysfunction Services] [Coinsurance] [Tier [2]]	[0% - 100% [until the [Temporomandibular Joint (TMJ) or Craniomandibular Joint (CMJ) Dysfunction Services] [Tier [2]] Out-of-Pocket Limits are satisfied; [then Tier [X];] [100% thereafter.]]	[0% - 100% [until the [Temporomandibular Joint (TMJ) or Craniomandibular Joint (CMJ) Dysfunction Services] [Tier [2]] Out-of-Pocket Limits are satisfied; [then Tier [X];] [100% thereafter.]]	[0% - 100% [until the [Temporomandibular Joint (TMJ) or Craniomandibular Joint (CMJ) Dysfunction Services] [Tier [2]] Out-of-Pocket Limits are satisfied; [then Tier [X];] [100% thereafter.]]
[Tier [2]] [Temporomandibular Joint (TMJ) or Craniomandibular Joint (CMJ) Dysfunction Services] [Out-of-Pocket Limit][each [Calendar Year] [Benefit Period] [Time Period] [Plan Year]] [Individual]	[$0 - $25,000 / Not applicable]	[$0 - $25,000 / Not applicable]	[$0 - $25,000 / an additional $0 - $10,000]

[Family]	[$0 - $75,000 / Not applicable]	[$0 - $75,000 / Not applicable]	[$0 - $75,000 / an additional $0 - $30,000]
[Temporomandibular Joint (TMJ) or Craniomandibular Joint (CMJ) Dysfunction Services] [Coinsurance] [Tier [X]]	[0% - 100% [until the [Temporomandibular Joint (TMJ) or Craniomandibular Joint (CMJ) Dysfunction Services] [Tier [X]] Out-of-Pocket Limits are satisfied;] [then Tier [X + [1]];] [100% thereafter.]]	[0% - 100% [until the [Temporomandibular Joint (TMJ) or Craniomandibular Joint (CMJ) Dysfunction Services] [Tier [X]] Out-of-Pocket Limits are satisfied;] [then Tier [X + [1]];] [100% thereafter.]]	[0% - 100% [until the [Temporomandibular Joint (TMJ) or Craniomandibular Joint (CMJ) Dysfunction Services] [Tier [X]] Out-of-Pocket Limits are satisfied;] [then Tier [X + [1]];] [100% thereafter.]]
[Tier [X]] [Temporomandibular Joint (TMJ) or Craniomandibular Joint (CMJ) Dysfunction Services][Out-of-Pocket Limit][each [Calendar Year] [Benefit Period] [Time Period] [Plan Year]] [Individual] [Family]	 [$0 - $25,000 / Not applicable] [$0 - $75,000 / Not applicable]	 [$0 - $25,000 / Not applicable] [$0 - $75,000 / Not applicable]	 [$0 - $25,000 / an additional $0 - $10,000] [$0 - $75,000 / an additional $0 - $30,000]
[[Temporomandibular Joint (TMJ) or Craniomandibular Joint (CMJ) Dysfunction Services] [Out-of-Pocket Limits]] [Individual] [Family]	 [$XXX] [$XXX]	 [$XXX] [$XXX]	 [$XXX] [$XXX]

BEN: 120.001.001.GE

[**Diabetic Services**:]			
[All services, supplies and treatments apply to the [Outpatient] [and] [Calendar Year] [and] [Plan Year] [Benefit Period] [Per Cause] Maximum Benefit]			
[Subject to [Plan] [and] [Outpatient] [Integrated] [Per Cause] Deductible] and [Plan] [and] [Outpatient] Coinsurance [unless otherwise specified]]			
[Covered Charges include: • [Eye Examinations: [Both eyes] [1] per [Calendar Year] [Plan Year] [per Covered Person]] • [Foot Examination: [Both feet] [1] per [Calendar Year] [Plan Year] [per Covered Person]] • [Nutritional Counseling: [When first diagnosed] [or] [and] [when changes in condition occur] [per Covered Person]]]			
[Not Covered]			
	[[Select] Participating Provider [Benefits]]	**[Participating Provider [Benefits] / Network Provider**	**[Non-[Select] Participating Provider [Benefits]/ Non-**

		[Benefits]]	**Participating Provider [Benefits]/ Non-Network Provider [Benefits]]**
[[Diabetic Services] Maximum [Lifetime] [Calendar Year] [Plan Year] [Benefit Period] [Per Cause] [Monthly] [Daily] Benefit]	[$XXX] [per Covered Person]	[$XXX] [per Covered Person]	[$XXX] [per Covered Person]
[[Diabetic Services]l Maximum [Lifetime] [Calendar Year] [Plan Year] [Benefit Period] [Per Cause] [Monthly] [Daily] Benefit] [due to an [Accidental Injury] [Injury] [or] [underlying Sickness]	[$XXX] [per Covered Person]	[$XXX] [per Covered Person]	[$XXX] [per Covered Person]
[Benefits for Diabetic Services are payable at [0-100%] [with a [$10-$100] Copayment] when a Designated Specialty Service Provider is used. If a Designated Specialty Service Provider is not used, [Covered Charges will be [paid at the [Non-][Participating] [or] [applicable] Coinsurance] [reduced by [$1 - $3,000] [1% - 50%]][limited to [$XXX] per [Calendar] [Plan] Year] [per Covered Person] [after the Covered Person has paid any applicable Copayment, Deductible or other fees.] [These limitations will apply to all treatment rendered by a provider that is not designated as a Designated Specialty Service Provider regardless of whether the provider is a [Network Provider,] [Participating Provider,] [or] [Select Participating Provider].]			

BEN: 125.001.001.GE

[**Growth Hormone Therapy Services**:]			
[All services, supplies and treatments apply to the [Outpatient] [Calendar Year] [Plan Year] [Benefit Period] [Per Cause] Maximum Benefit]			
[Subject to [Plan] [Outpatient] [Integrated] [Per Cause] Deductible] and [Plan] [Outpatient] Coinsurance [unless otherwise specified]]			
[Benefits for Growth Hormone Therapy Services are limited to a Maximum [Lifetime] [Calendar Year] [Plan Year] [Monthly] [Daily] [Benefit Period] [Per Cause] Benefit of [$XXX]] [per Covered Person].]			
[Growth Hormone Therapy Services Benefit Waiting Period is [[12] months] [[365] days]]			
[Not Covered]			
	[[Select] Participating Provider [Benefits]]	**[Participating Provider [Benefits] / Network Provider [Benefits]]**	**[Non-[Select] Participating Provider [Benefits]/ Non-Participating Provider [Benefits]/ Non-Network Provider [Benefits]]**
[[Growth Hormone Therapy Services] Maximum [Lifetime] [Calendar Year] [Plan Year] [Benefit Period] [Per Cause] [Monthly] [Daily] Benefit]	[$XXX] [per Covered Person]	[$XXX] [per Covered Person]	[$XXX] [per Covered Person]

BEN: 130.001.001.GE

[**Tonsils and Adenoids**:]
[All services, supplies and treatments apply to the [Outpatient] [and] [Calendar Year] [and] [Plan Year] [Benefit Period] [Per Cause] Maximum Benefit]
[Subject to [Plan] [and] [Outpatient] [Integrated] [Per Cause] Deductible] and [Plan] [and] [Outpatient] Coinsurance [unless otherwise specified].]
[Benefits for Tonsils and Adenoids Services are limited to a Maximum [Lifetime] [Calendar Year] [Plan Year] [Benefit Period] [Per Cause] [Monthly] [Daily] Benefit of [$500 - $2,000] [per Covered Person]]
[[Tonsils and Adenoids Services] Benefit Waiting Period is [[12] months] [[365] days].]
[Not Covered]

	[[Select] Participating Provider [Benefits]]	**[Participating Provider [Benefits] / Network Provider [Benefits]]**	**[Non-[Select] Participating Provider [Benefits]/ Non-Participating Provider [Benefits]/ Non-Network Provider [Benefits]]**
[[Tonsils and Adenoids Services] Maximum [Lifetime] [Calendar Year] [Plan Year] [Benefit Period] [Per Cause] [Monthly] [Daily] Benefit]	[$XXX] [per Covered Person]	[$XXX] [per Covered Person]	[$XXX] [per Covered Person]
[Benefits for Tonsils and Adenoids Services are payable at [0-100%] [with a [$10-$100] Copayment] when a Designated Specialty Service Provider is used. If a Designated Specialty Service Provider is not used, [Covered Charges will be [paid at the [Non-][Participating] [or] [applicable] Coinsurance] [reduced by [$1 - $3,000] [1% - 50%]][limited to [$XXX] per [Calendar] [Plan] Year] [per Covered Person] [after the Covered Person has paid any applicable Copayment, Deductible or other fees.] [These limitations will apply to all treatment rendered by a provider that is not designated as a Designated Specialty Service Provider regardless of whether the provider is a [Network Provider,] [Participating Provider,] [or] [Select Participating Provider].]			

BEN: 135.001.001.GE

[**Bunions,**] [**Hemorrhoids**] [**and**] [**Varicose Veins**]:			
[All services, supplies and treatments apply to the [Outpatient] [Calendar Year] [Plan Year] [Benefit Period] [Per Cause] Maximum Benefit]			
[Subject to [Plan] [Inpatient] [Outpatient] [Integrated] [Per Cause] Deductible] and Coinsurance [unless otherwise specified].]			
[Benefits for [Bunions,] [Hemorrhoids] [and] [Varicose Veins] Services are limited to a Maximum [Lifetime] [Calendar Year] [Plan Year] [Benefit Period] [Per Cause] [Monthly] [Daily] Benefit of [$500 - $2,000] [per Covered Person]			
[Benefits for [Bunions,] [Hemorrhoids] [and] [Varicose Veins] Services Benefit Waiting Period is [[12] months] [[365] days].]			
[Not Covered]			
	[[Select] Participating Provider [Benefits]]	**[Participating Provider [Benefits] / Network Provider [Benefits]]**	**[Non-[Select] Participating Provider [Benefits]/ Non-Participating Provider [Benefits]/ Non-Network Provider [Benefits]]**
[[Bunions,] [Hemorrhoids] [and] [Varicose Veins]Services] Maximum [Lifetime] [Calendar Year] [Plan Year] [Benefit Period] [Per Cause] [Monthly] [Daily] Benefit]	[$XXX] [per Covered Person]	[$XXX] [per Covered Person]	[$XXX] [per Covered Person]
[Benefits for [Bunions,] [Hemorrhoids] [and] [Varicose Veins] Services are payable at [0-100%] [with a [$10-$100] Copayment] when a Designated Specialty Service Provider is used. If a [Designated Specialty Service Provider] is not used, [Covered Charges will be [paid at the [Non-][Participating] [or] [applicable] Coinsurance] [reduced by [$1 - $3,000] [1% - 50%]][limited to [$XXX] per [Calendar] [Plan] Year] [per Covered Person] [after the Covered Person has paid any applicable Copayment, Deductible or other fees.] [These limitations will apply to all treatment rendered by a provider that is not designated as a Designated Specialty Service Provider regardless of whether the provider is a [Network Provider,] [Participating Provider,] [or] [Select Participating Provider].]			

BEN: 140.001.001.GE

[**Inguinal Hernia**:]
[All services, supplies and treatments apply to the [Outpatient] [and] [Calendar Year] [and] [Plan Year] [Benefit

Period] [Per Cause] Maximum Benefit]			
[Subject to [Plan] [Inpatient] [and] [Outpatient] [Integrated] [Per Cause] Deductible] and [Plan] [Inpatient] [and] [Outpatient] Coinsurance [unless otherwise specified].]			
[Benefits for Inguinal Hernia Services are limited to a Maximum [Lifetime] [Calendar Year] [Plan Year] [Benefit Period] [Per Cause] [Monthly] [Daily] Benefit of [$250 - $2,000] [per Covered Person].]			
[Inguinal Hernia Services Benefit Waiting Period is [[12] months] [[365] days].]			
[Not Covered]			
	[[Select] Participating Provider [Benefits]]	**[Participating Provider [Benefits] / Network Provider [Benefits]]**	**[Non-[Select] Participating Provider [Benefits]/ Non-Participating Provider [Benefits]/ Non-Network Provider [Benefits]]**
[[Inguinal Hernia]Services] Maximum [Lifetime] [Calendar Year] [Plan Year] [Benefit Period] [Per Cause] [Monthly] [Daily] Benefit]	[$XXX] [per Covered Person]	[$XXX] [per Covered Person]	[$XXX] [per Covered Person]
[Benefits for Inguinal Hernia Services are payable at [0-100%] [with a [$10-$100] Copayment] when a Designated Specialty Service Provider is used. If a Designated Specialty Service Provider is not used, [Covered Charges will be [paid at the [Non-][Participating] [or] [applicable] Coinsurance] [reduced by [$1 - $3,000] [1% - 50%]][limited to [$XXX] per [Calendar] [Plan] Year] [per Covered Person] [after the Covered Person has paid any applicable Copayment, Deductible or other fees.] [These limitations will apply to all treatment rendered by a provider that is not designated as a Designated Specialty Service Provider regardless of whether the provider is a [Network Provider,] [Participating Provider,] [or] [Select Participating Provider].]			

BEN: 145.001.001.GE

[**Blood Product Transfusions**:]			
[All services, supplies and treatments apply to the [Outpatient] [and] [Calendar Year] [Plan Year] [Benefit Period] [and] [Per Cause] Maximum Benefit]			
[Subject to[Integrated] [Plan][Inpatient][and] [Outpatient] [Per Cause] Deductible] and [Plan][Inpatient][and] [Outpatient] [and] Coinsurance [unless otherwise specified]]			
	[[Select] Participating Provider [Benefits]]	**[Participating Provider [Benefits] / Network Provider [Benefits]]**	**[Non-[Select] Participating Provider [Benefits]/ Non-Participating Provider [Benefits]/ Non-Network Provider [Benefits]]**
[Blood Product Transfusions Maximum [Lifetime] [Calendar Year] [Plan Year] [Benefit Period] [Per Cause] [Monthly] [Daily] Benefit]	[$XXX] [per Covered Person]	[$XXX] [per Covered Person]	[$XXX] [per Covered Person]
[Blood Product Transfusions Deductible] [Individual] [Integrated] [Family]	 [$XXX] [$XXX]	 [$XXX] [$XXX]	 [$XXX] [$XXX]
[The [Blood Product Transfusions Deductible] does [not] apply to the Plan Deductible or Total Out-of-Pocket Limits.]			
[[Non-Participating] [Non-network] Provider Deductible is in addition to the [Participating] [Network] Provider Deductible.]			
[Once [[2] or more Covered Persons have collectively met] the maximum Family Deductible [has been met], no additional Deductible will be taken during the [Calendar Year] [Plan Year] [Benefit Period] [Time Period].]			
[Access] [Fee]	[None / $XXX per	[None / $XXX per	[None / $XXX per

	Blood Product Transfusions]	Blood Product Transfusions]	Blood Product Transfusions]
[Copayment]	[None / $XXX per Blood Product Transfusions]	[None / $XXX per Blood Product Transfusions]	[None / $XXX per Blood Product Transfusions]
[Blood Product Transfusions] [Coinsurance] [Tier [1]]	[0% - 100% [until the [Blood Product Transfusions] [Tier [1]] Out-of-Pocket Limits are satisfied; [then Tier [2];] [100% thereafter.]]	[0% - 100% [until the [Blood Product Transfusions] [Tier [1]] Out-of-Pocket Limits are satisfied; [then Tier [2];] [100% thereafter.]]	[0% - 100% [until the [Blood Product Transfusions] [Tier [1]] Out-of-Pocket Limits are satisfied; [then Tier [2];] [100% thereafter.]]
[Tier [1]] [Blood Product Transfusions] [Out-of-Pocket Limit] [each [Calendar Year] [Benefit Period] [Time Period] [Plan Year]] [Individual] [Family]	[$0 - $25,000 / Not applicable] [$0 - $75,000 / Not applicable]	[$0 - $25,000 / Not applicable] [$0 - $75,000 / Not applicable]	[$0 - $25,000 / an additional $0 - $10,000] [$0 - $75,000 / an additional $0 - $30,000]
[Blood Product Transfusions] [Coinsurance] [Tier [2]]	[0% - 100% [until the [Blood Product Transfusions] [Tier [2]] Out-of-Pocket Limits are satisfied; [then Tier [X];] [100% thereafter.]]	[0% - 100% [until the [Blood Product Transfusions] [Tier [2]] Out-of-Pocket Limits are satisfied; [then Tier [X];] [100% thereafter.]]	[0% - 100% [until the [Blood Product Transfusions] [Tier [2]] Out-of-Pocket Limits are satisfied; [then Tier [X];] [100% thereafter.]]
[Tier [2]] [Blood Product Transfusions] [Out-of-Pocket Limit] [each [Calendar Year] [Benefit Period] [Time Period] [Plan Year]] [Individual] [Family]	[$0 - $25,000 / Not applicable] [$0 - $75,000 / Not applicable]	[$0 - $25,000 / Not applicable] [$0 - $75,000 / Not applicable]	[$0 - $25,000 / an additional $0 - $10,000] [$0 - $75,000 / an additional $0 - $30,000]
[Blood Product Transfusions] [Coinsurance] [Tier [X]]	[0% - 100% [until the [Blood Product Transfusions] [Tier [X]] Out-of-Pocket Limits are satisfied;] [then Tier [X + [1]];] [100% thereafter.]]	[0% - 100% [until the [Blood Product Transfusions] [Tier [X]] Out-of-Pocket Limits are satisfied [100% thereafter.]]	[0% - 100% [until the [Blood Product Transfusions] [Tier [X]] Out-of-Pocket Limits are satisfied;] [then Tier [X + [1]];] [100% thereafter.]]

[Tier [X]] [Blood Product Transfusions] Out-of-Pocket Limit [each [Calendar Year] [Benefit Period] [Time Period] [Plan Year]] [Individual] [Family]	[$0 - $25,000 / Not applicable] [$0 - $75,000 / Not applicable]	[$0 - $25,000 / Not applicable] [$0 - $75,000 / Not applicable]	[$0 - $25,000 / an additional $0 - $10,000] [$0 - $75,000 / an additional $0 - $30,000]
[[Blood Product Transfusions] Out-of-Pocket Limits] [Individual] [Family]	[$XXX] [$XXX]	[$XXX] [$XXX]	[$XXX] [$XXX]
[Benefits for [Blood Product Transfusions] are payable at [0-100%] [with a [$10-$100] Copayment] when a [Designated Specialty Service Provider] is used. If a [Designated Specialty Service Provider] is not used, [Covered Charges will be [paid at the [Non-][Participating] [or] [applicable] Coinsurance] [reduced by [$1 - $3,000] [1% - 50%]][limited to [$XXX] per [Calendar] [Plan] Year] [per Covered Person] [after the Covered Person has paid any applicable Copayment, Deductible or other fees.] [These limitations will apply to all treatment rendered by a provider that is not designated as a [Designated Specialty Service Provider] regardless of whether the provider is a [Network Provider,] [Participating Provider,] [or] [Select Participating Provider].]			

BEN: 150.001.001.GE

[**Transplants**:]			
[Subject to [Plan] [and] [Inpatient] [and] [Outpatient] [Integrated] Deductible and [Plan] [and] [Inpatient] [and] [Outpatient] Coinsurance [unless otherwise specified]]			
[Benefit for Transplants are limited to [Outpatient] [and] [Calendar Year] [and] [Plan Year] [and] [Monthly] [and] [Daily] [Benefit Period] [Per Cause] [and] [Lifetime] Maximum Benefit]			
[Donor Expenses are limited to a Maximum Benefit of [$5,000 - $25,000]]			
[Not Covered]			
[The following Covered Transplants are subject to the [Outpatient] [and] [Calendar Year] [and] [Plan Year and] [Monthly] [and] [Daily] [Benefit Period] [Per Cause] [and] [Lifetime] Maximum Benefit]: • [Kidney] • [Cornea] • [Skin]]			
[The following Covered Transplants subject to the [Maximum Transplant Benefit] [Outpatient] and [Calendar Year] and [Plan Year] [and] [Monthly] [and] [Daily] [Benefit Period] [Per Cause] [and] [Lifetime] [Maximum Benefit]: • Lung(s) • Heart • Simultaneous heart/lung • Liver • Simultaneous kidney/pancreas • Allogeneic and autologous bone marrow transplant/stem cell rescue]			
	[Designated Specialty Service Provider /[Select] Participating Provider /Designated Transplant Provider [Benefits]]	**[Participating Provider [Benefits] / Network Provider [Benefits]] [and Non-Participating/Non-Network Provider]**	**[Non-[Select] Participating Provider [Benefits]/ Non-Participating Provider [Benefits]/ Non-Network Provider [Benefits]]**
[Maximum Transplant Benefit]	[Lifetime Maximum	[$100,000] [Lifetime]	[$100,000] [Lifetime]

	Benefit] [[$100,000] Benefit Period Maximum] [per Covered Person]	[Calendar Year] [Plan Year] [Benefit Period] Maximum [Benefit] [per Covered Person]	[Calendar Year] [Plan Year] [Benefit Period] Maximum [Benefit] [per Covered Person]
[Travel Expenses] will be covered up to a [$5,000 - $20,000] Maximum Benefit when a [Designated Specialty Service Provider][Select Participating Provider][Designated Transplant Provider Benefits] is used as described in the Covered Medical Benefits section]			

BEN: 155.001.001.GE

[**Behavioral Health** [**and Substance Abuse**]:]			
[Subject to [Plan] [and] [Inpatient] [and] [Outpatient] [Integrated] [Per Cause] Deductible] [and] [Plan] [and] [Inpatient] [and] [Outpatient] [Coinsurance] [unless otherwise specified].]			
[Benefits for Inpatient treatment in a state licensed [Acute Behavioral Health Inpatient Facility] [or] [Behavioral Health Rehabilitation and Residential Facility] are limited to [$1,000 - $5,000] [or] [10-50] [days] [whichever is [less] [greater]] each [Calendar Year] [Plan Year] [Benefit Period] [Per Cause] [per] [Covered Person] [Family]]			
[Benefits for Outpatient treatment by a Health Care Practitioner [or a state licensed [Intensive Outpatient Behavioral Health Program] [or] [Partial Hospital and Day Treatment Behavioral Health Facility or Program] are limited to [$50] for each visit up to [[XX] visits] [$250 - $1,000] each [Calendar Year] [Plan Year] [Benefit Period] [Per Cause] [per] [Covered Person] [Family]]			
[Benefits for Inpatient treatment in a state licensed [Acute Behavioral Health Inpatient Facility] [or] [Behavioral Health Rehabilitation and Residential Facility] and Outpatient treatment by a Health Care Practitioner [or a state licensed [Intensive Outpatient Behavioral Health Program] [or] [Partial Hospital and Day Treatment Behavioral Health Facility or Program] are limited to a combined Maximum Benefit of [$2,000 - $6,000] each [Calendar Year] [Plan Year] [Benefit Period] [Per Cause] [per] [Covered Person] [Family]]			
[Benefits for Inpatient treatment in a state licensed [Acute Behavioral Health Inpatient Facility] [or] [Behavioral Health Rehabilitation and Residential Facility] and Outpatient treatment by a Health Care Practitioner [or a state licensed [Intensive Outpatient Behavioral Health Program] [or] [Partial Hospital and Day Treatment Behavioral Health Facility or Program] are limited to a Lifetime Maximum Benefit of [$5,000 - $25,000] [per] [Covered Person] [Family]]			
[Behavioral Health [and Substance Abuse] Benefit Waiting Period is [[12] months] [[365] days]]			
[The [Behavioral Health] [and Substance Abuse] [Deductible] [and] [Coinsurance] does [not] apply to the [Plan Deductible] [or] [Total Out-of-Pocket Limits.]]			
[The [Behavioral Health] [and Substance Abuse] Coinsurance] will [not] increase to 100% after the Plan Out of Pocket is satisfied.] [The Behavioral Health Coinsurance, not paid by us, will not apply toward any Out of Pocket Limit.]]			
[Not Covered]			
	[[Select] Participating Provider [Benefits]]	**[Participating Provider [Benefits] / Network Provider [Benefits]]**	**[Non-[Select] Participating Provider [Benefits]/ Non-Participating Provider [Benefits]/ Non-Network Provider [Benefits]]**
[[Behavioral Health [and Substance Abuse]] Maximum [Lifetime] [Calendar Year] [Plan Year] [Benefit Period] [Per Cause] [Monthly] [Daily] Benefit]	[$XXX] [[XX] number of visits] [per Covered Person]	[$XXX] [[XX] number of visits] [per Covered Person]	[$XXX] [[XX] number of visits] [per Covered Person]
[[Behavioral Health [and Substance Abuse]] Maximum [Lifetime] [Calendar Year] [Plan Year] [Benefit Period] [Per Cause] [Monthly] [Daily] Benefit] [due to an [Accidental Injury] [Injury] [or] [underlying Sickness]	[$XXX] [[XX] number of visits] [per Covered Person]	[$XXX] [[XX] number of visits] [per Covered Person]	[$XXX] [[XX] number of visits] [per Covered Person]
[Behavioral Health [and Substance Abuse] Deductible]			

[Individual] [Integrated] [Family]	[$XXX] [$XXX]	[$XXX] [$XXX]	[$XXX] [$XXX]
[[Non-Participating] [Non-network] Provider Deductible is in addition to the [Participating] [Network] Provider Deductible.]			
[Once [[2] or more Covered Persons have collectively met] the maximum Family Deductible [[has been met]], no additional Deductible will be taken during the [Calendar Year] [Plan Year] [Benefit Period] [Time Period].]			
[Behavioral Health [and Substance Abuse]] [Coinsurance] [Tier [1]]	[0% - 100% [until the [Behavioral Health [and Substance Abuse] [Maximum Benefit is Met] [Tier [1]] Out-of-Pocket Limits are satisfied; [then Tier [2];] [100% thereafter.]]	[0% - 100% [until the [Behavioral Health [and Substance Abuse] [Maximum Benefit is Met] [Tier [1]] Out-of-Pocket Limits are satisfied; [then Tier [2];] [100% thereafter.]]	[0% - 100% [until the [Behavioral Health [and Substance Abuse] [Maximum Benefit is Met] [Tier [1]] Out-of-Pocket Limits are satisfied; [then Tier [2];] [100% thereafter.]]
[Tier [1]] [Behavioral Health [and Substance Abuse]] [Out-of-Pocket Limit] [each [Calendar Year] [Benefit Period] [Time Period] [Plan Year] [Individual] [Family]	[$0 - $25,000 / Not applicable] [$0 - $75,000 / Not applicable]	[$0 - $25,000 / Not applicable] [$0 - $75,000 / Not applicable]	[$0 - $25,000 / an additional $0 - $10,000] [$0 - $75,000 / an additional $0 - $30,000]
[Behavioral Health [and Substance Abuse]][Coinsurance] [Tier [2]]	[0% - 100% [until the [Behavioral Health [and Substance Abuse] [Maximum Benefit is Met] [Tier [2]] Out-of-Pocket Limits are satisfied; [then Tier [X];] [100% thereafter.]]	[0% - 100% [until the [Behavioral Health [and Substance Abuse] [Maximum Benefit is Met] [Tier [2]] Out-of-Pocket Limits are satisfied; [then Tier [X];] [100% thereafter.]]	[0% - 100% [until the [Behavioral Health [and Substance Abuse] [Maximum Benefit is Met] [Tier [2]] Out-of-Pocket Limits are satisfied; [then Tier [X];] [100% thereafter.]]
[Tier [2] [Behavioral Health [and Substance Abuse]] [Out-of-Pocket Limit] [each [Calendar Year] [Benefit Period] [Time Period] [Plan Year] [Individual] [Family]	[$0 - $25,000 / Not applicable] [$0 - $75,000 / Not applicable]	[$0 - $25,000 / Not applicable] [$0 - $75,000 / Not applicable]	[$0 - $25,000 / an additional $0 - $10,000] [$0 - $75,000 / an additional $0 - $30,000]
[Behavioral Health [and Substance Abuse]] [Coinsurance] [Tier [X]]	[0% - 100% [until the [Behavioral Health [and Substance Abuse] [Maximum Benefit is Met] [Tier [X]] Out-of-Pocket Limits are	[0% - 100% [until the [Behavioral Health [and Substance Abuse] [Maximum Benefit is Met] [Tier [X]] Out-of-Pocket	[0% - 100% [until the [Behavioral Health [and Substance Abuse] [Maximum Benefit is Met] [Tier [X]] Out-of-Pocket Limits are

	satisfied;] [then Tier [X + [1]];] [100% thereafter.]]	Limits are satisfied;] [then Tier [X + [1]];] [100% thereafter.]]	satisfied;] [then Tier [X + [1]];] [100% thereafter.]]
[Tier [X]] [Behavioral Health [and Substance Abuse]][Out-of-Pocket Limit] [each [Calendar Year] [Benefit Period] [Time Period] [Plan Year] [Individual]	[$0 - $25,000 / Not applicable]	[$0 - $25,000 / Not applicable]	[$0 - $25,000 / an additional $0 - $10,000]
[Family]	[$0 - $75,000 / Not applicable]	[$0 - $75,000 / Not applicable]	[$0 - $75,000 / an additional $0 - $30,000]
[[Behavioral Health [and Substance Abuse Services]] [Out-of-Pocket Limits] [Individual]	[$XXX]	[$XXX]	[$XXX]
[Family]	[$XXX]	[$XXX]	[$XXX]
[Benefits for Behavioral Health [and Substance Abuse Services] are payable at [0-100%] [with a [$10-$100] Copayment] when a Designated Specialty Service Provider is used. If a Designated Specialty Service Provider is not used, [Covered Charges will be [paid at the [Non-][Participating] [or] [applicable] Coinsurance] [reduced by [$1 - $3,000] [1% - 50%]][limited to [$XXX] per [Calendar] [Plan] Year] [per Covered Person] [after the Covered Person has paid any applicable Copayment, Deductible or other fees.] [These limitations will apply to all treatment rendered by a provider that is not designated as a Designated Specialty Service Provider regardless of whether the provider is a [Network Provider,] [Participating Provider,] [or] [Select Participating Provider].]			

BEN: 160.001.001.GE

[**Substance Abuse**:]
[Subject to [Plan] [and] [Inpatient] [and] [Outpatient] [Integrated] [Per Cause] Deductible] and [Plan] [and] [Inpatient] [and] [Outpatient] Coinsurance [unless otherwise specified]]
[Benefits for Inpatient treatment in a state licensed [Acute Behavioral Health Inpatient Facility] [or] [Behavioral Health Rehabilitation and Residential Facility] are limited to [$1,000 - $5,000] [or] [10-50] [days] [whichever is [less] [greater]] each [Calendar Year] [Plan Year] [Benefit Period] [Per Cause] [per] [Covered Person] [Family]]
[Benefits for Outpatient treatment by a Health Care Practitioner [or a state licensed [Intensive Outpatient Behavioral Health Program] [or] [Partial Hospital and Day Treatment Behavioral Health Facility or Program] are limited to [$25 - $100] for each visit up to [[XX] visits] [$250 - $100] each [Calendar Year] [Plan Year] [Benefit Period] [Per Cause] [per] [Covered Person] [Family]]
[Benefits for Inpatient treatment in a state licensed [Acute Behavioral Health Inpatient Facility] [or] [Behavioral Health Rehabilitation and Residential Facility] and Outpatient treatment by a Health Care Practitioner [or a state licensed [Intensive Outpatient Behavioral Health Program] [or] [Partial Hospital and Day Treatment Behavioral Health Facility or Program] are limited to a combined Maximum Benefit of [$1,500 - $6,000] each [Calendar Year] [Plan Year] [Benefit Period] [Per Cause] [per] [Covered Person] [Family]]
[Benefits for Inpatient treatment in a state licensed [Acute Behavioral Health Inpatient Facility] [or] [Behavioral Health Rehabilitation and Residential Facility] and Outpatient treatment by a Health Care Practitioner [or a state licensed [Intensive Outpatient Behavioral Health Program] [or] [Partial Hospital and Day Treatment Behavioral Health Facility or Program] are limited to a Lifetime Maximum Benefit of [$5,000 - $20,000] [per] [Covered Person] [Family]]
[Substance Abuse] Benefit Waiting Period is [[12] months] [[365] days]]
[Not Covered]

	[[Select] Participating Provider [Benefits]]	**[Participating Provider [Benefits] / Network Provider [Benefits]]**	**[Non-[Select] Participating Provider [Benefits]/ Non-Participating Provider [Benefits]/ Non-Network Provider [Benefits]]**
[[Substance Abuse] Maximum [Lifetime] [Calendar Year] [Plan Year] [Benefit Period] [Per Cause] [Monthly] [Daily] Benefit]	[$XXX] [[XX] number of visits] [per Covered Person]	[$XXX] [[XX] number of visits] [per Covered Person]	[$XXX] [[XX] number of visits] [per Covered Person]
[[Substance Abuse] Maximum [Lifetime] [Calendar Year] [Plan Year] [Benefit Period] [Per Cause] [Monthly] [Daily] Benefit] [due to an [Accidental Injury] [Injury] [or] [underlying Sickness]]	[$XXX] [[XX] number of visits] [per Covered Person]	[$XXX] [[XX] number of visits] [per Covered Person]	[$XXX] [[XX] number of visits] [per Covered Person]
[Substance Abuse Deductible] [Individual] [Integrated] [Family]	[$XXX] [$XXX]	[$XXX] [$XXX]	[$XXX] [$XXX]
[The [Substance Abuse Deductible] does [not] apply to the Plan Deductible or Total Out-of-Pocket Limits.]			
[[Non-Participating] [Non-network] Provider Deductible is in addition to the [Participating] [Network] Provider Deductible.]			
[Once [[2] or more Covered Persons have collectively met] the maximum Family Deductible [has been met], no additional Deductible will be taken during the [Calendar Year] [Plan Year] [Benefit Period] [Time Period].]			
[Substance Abuse] Coinsurance [Tier [1]]	[0% - 100% [until the [Substance Abuse Services] [Tier [1]] Out-of-Pocket Limits are satisfied; [then Tier [2];] [100% thereafter.]]	[0% - 100% [until the [Substance Abuse Services] [Tier [1]] Out-of-Pocket Limits are satisfied; [then Tier [2];] [100% thereafter.]]	[0% - 100% [until the [Substance Abuse Services] [Tier [1]] Out-of-Pocket Limits are satisfied; [then Tier [2];] [100% thereafter.]]
[Tier [1]] [Substance Abuse] Out-of-Pocket Limit [each [Calendar Year] [Benefit Period] [Time Period] [Plan Year]] [Individual] [Family]	[$0 - $25,000 / Not applicable] [$0 - $75,000 / Not applicable]	[$0 - $25,000 / Not applicable] [$0 - $75,000 / Not applicable]	[$0 - $25,000 / an additional $0 - $10,000] [$0 - $75,000 / an additional $0 - $30,000]
[Substance Abuse] [Coinsurance] [Tier [2]]	[0% - 100% [until the [Substance Abuse Services] [Tier [2]] Out-of-Pocket Limits are satisfied; [then Tier [X];] [100% thereafter.]]	[0% - 100% [until the [Substance Abuse Services] [Tier [2]] Out-of-Pocket Limits are satisfied; [then Tier [X];] [100% thereafter.]]	[0% - 100% [until the [Substance Abuse Services] [Tier [2]] Out-of-Pocket Limits are satisfied; [then Tier [X];] [100% thereafter.]]

[Tier [2]] [Substance Abuse] Out-of-Pocket Limit [each [Calendar Year] [Benefit Period] [Time Period] [Plan Year]] [Individual]	[$0 - $25,000 / Not applicable]	[$0 - $25,000 / Not applicable]	[$0 - $25,000 / an additional $0 - $10,000]
[Family]	[$0 - $75,000 / Not applicable]	[$0 - $75,000 / Not applicable]	[$0 - $75,000 / an additional $0 - $30,000]
[Substance Abuse] [Coinsurance] [Tier [X]]	[0% - 100% [until the [Substance Abuse Services] [Tier [X]] Out-of-Pocket Limits are satisfied;] [then Tier [X + [1]];] [100% thereafter.]]	[0% - 100% [until the [Substance Abuse Services] [Tier [X]] Out-of-Pocket Limits are satisfied;] [then Tier [X + [1]];] [100% thereafter.]]	[0% - 100% [until the [Substance Abuse Services] [Tier [X]] Out-of-Pocket Limits are satisfied;] [then Tier [X + [1]];] [100% thereafter.]]
[Tier [X]] [Substance Abuse] Out-of-Pocket Limit [each [Calendar Year] [Benefit Period] [Time Period] [Plan Year]] [Individual]	[$0 - $25,000 / Not applicable]	[$0 - $25,000 / Not applicable]	[$0 - $25,000 / an additional $0 - $10,000]
[Family]	[$0 - $75,000 / Not applicable]	[$0 - $75,000 / Not applicable]	[$0 - $75,000 / an additional $0 - $30,000]
[Substance Abuse Services] Out-of-Pocket Limits] [Individual]	[$XXX]	[$XXX]	[$XXX]
[Family]	[$XXX]	[$XXX]	[$XXX]
[Benefits for [Substance Abuse Services] are payable at [0-100%] [with a [$10-$100] Copayment] when a [Designated Specialty Service Provider] is used. If a [Designated Specialty Service Provider] is not used, [Covered Charges will be [paid at the [Non-][Participating] [or] [applicable] Coinsurance] [reduced by [$1 - $3,000] [1% - 50%]][limited to [$XXX] per [Calendar] [Plan] Year] [per Covered Person] [after the Covered Person has paid any applicable Copayment, Deductible or other fees.] [These limitations will apply to all treatment rendered by a provider that is not designated as a [Designated Specialty Service Provider] regardless of whether the provider is a [Network Provider,] [Participating Provider,] [or] [Select Participating Provider].]			

BEN: 165.001.001.GE

[**Reconstructive Surgery**:]			
[All services, supplies and treatments apply to the [Inpatient] [and] [Outpatient] [and] [Calendar Year] [Plan Year] [Benefit Period] [Per Cause] Maximum Benefit]			
[Subject to [Plan] [Integrated] [Inpatient] [Outpatient] [Per Cause] Deductible] and [Plan] [Inpatient] [Outpatient] Coinsurance [unless otherwise specified]]			
	[[Select] Participating Provider [Benefits]]	**[Participating Provider [Benefits] / Network Provider [Benefits]]**	**[Non-[Select] Participating Provider [Benefits]/ Non-Participating Provider [Benefits]/ Non-Network Provider [Benefits]]**

[[Reconstructive Surgery] [Lifetime] [Calendar Year] [Plan Year] [Benefit Period] [Per Cause] [Monthly] [Daily] Maximum Benefit]	[$XXX] [per Covered Person]	[$XXX] [per Covered Person]	[$XXX] [per Covered Person]
[[Reconstructive Surgery] [Lifetime] [Calendar Year] [Plan Year] [Benefit Period] [Per Cause] [Monthly] [Daily] Maximum Benefit] [due to an [Accidental Injury] [Injury] [or] [underlying Sickness]	[$XXX] [per Covered Person]	[$XXX] [per Covered Person]	[$XXX] [per Covered Person]

BEN: 170.001.001.GE

[**Dental Services**:]			
[All services, supplies and treatments apply to the [Outpatient] [and] [Calendar Year] [and] [Plan Year] [and] [Benefit Period] [Per Cause] Maximum Benefit]			
[Subject to [Plan] [and] [Outpatient] [Integrated] [Per Cause] Deductible] and [Plan] [and] [Outpatient] Coinsurance [unless otherwise specified]]			
[Benefits for Dental Services are limited to a Maximum [Lifetime] [Calendar Year] [Plan Year] [Benefit Period] [Per Cause] [Monthly] [Daily] Benefit of [$1,000 - $5,000] [unless due to an Accidental Injury [Injury] [or underlying Sickness] [per Covered Person]]			
[Benefits are limited to conditions present at birth or diagnosed before age [5]]			
[Treatment must begin within [90 days] and be completed within [365 days] of the Dental Injury.]			
[Dental Services Benefit Waiting Period is [12][Months] [[365] days].]			
[Not Covered]			
	[[Select] Participating Provider [Benefits]]	**[Participating Provider [Benefits] / Network Provider [Benefits]]**	**[Non-[Select] Participating Provider [Benefits]/ Non-participating Provider [Benefits]/ Non-Network Provider [Benefits]]**
[[Dental Services] Maximum [Lifetime] [Calendar Year] [Plan Year] [Benefit Period] [Per Cause] [Monthly] [Daily] Benefit]	[$XXX] [per Covered Person]	[$XXX] [per Covered Person]	[$XXX] [per Covered Person]
[Benefits for Dental Services are payable at [0-100%] [with a [$10-$100] Copayment] when a [Designated Specialty Service Provider] is used. If a [Designated Specialty Service Provider] is not used, [Covered Charges will be [paid at the [Non-][Participating] [or] [applicable] Coinsurance] [reduced by [$1 - $3,000] [1% - 50%]][limited to [$XXX] per [Calendar] [Plan] Year] [per Covered Person] [after the Covered Person has paid any applicable Copayment, Deductible or other fees.] [These limitations will apply to all treatment rendered by a provider that is not designated as a [Designated Specialty Service Provider] regardless of whether the provider is a [Network Provider,] [Participating Provider,] [or] [Select Participating Provider].]			

BEN: 175.001.001.GE

[**Intravenous Injectable Parenteral Drug Therapy** [**and Specialty Pharmaceuticals**]:]			
[All services, supplies and treatments apply to the [Outpatient] [Calendar Year] [Plan Year] [Benefit Period] [Per Cause] Maximum Benefit]			
[Subject to [Plan] [Outpatient] [Integrated] [Per Cause] Deductible] and Coinsurance [unless otherwise specified]]			
[Benefits for [Intravenous Injectable Parenteral Drug Therapy] [and Specialty Pharmaceuticals] Services are limited to a Maximum [Lifetime] [Calendar Year] [Plan Year] [Benefit Period] [Per Cause] [Monthly] [Daily] Benefit of [$XXX] [per Covered Person]]			
[Not Covered]			
	[[Select] Participating	**[Participating**	**[Non-[Select]**

	Provider [Benefits]]	**Provider [Benefits] / Network Provider [Benefits]]**	**Participating Provider [Benefits]/ Non-Participating Provider [Benefits]/ Non-Network Provider [Benefits]]**
[[Intravenous Injectable Parenteral Drug Therapy] [and Specialty Pharmaceuticals] Services] Maximum [Lifetime] [Calendar Year] [Plan Year] [Benefit Period] [Per Cause] [Monthly] [Daily] Benefit]	[$XXX] [per Covered Person]	[$XXX] [per Covered Person]	[$XXX] [per Covered Person]
[Benefits for [Intravenous Injectable Parenteral Drug Therapy Service] are payable at [0-100%] [with a [$10-$100] Copayment] when a Designated Specialty Service Provider is used. If a Designated Specialty Service Provider is not used, [Covered Charges will be [paid at the [Non-][Participating] [or] [applicable] Coinsurance] [reduced by [$1 - $3,000] [1% - 50%]][limited to [$XXX] per [Calendar] [Plan] Year] [per Covered Person] [after the Covered Person has paid any applicable Copayment, Deductible or other fees.] [These limitations will apply to all treatment rendered by a provider that is not designated as a Designated Specialty Service Provider regardless of whether the provider is a [Network Provider,] [Participating Provider,] [or] [Select Participating Provider].]			

BEN: 180.001.001.GE

[**Non-Intravenous Injectable Parenteral Drug Therapy**:]			
[All services, supplies and treatments apply to the [Outpatient] [Calendar Year] [Plan Year] [Benefit Period] [Per Cause] Maximum Benefit]			
[Subject to [Plan] [and] [Outpatient] [and] [Inpatient] [Integrated] [Per Cause] Deductible] and [Plan] [and] [Outpatient] and [Inpatient] Coinsurance [unless otherwise specified]			
[Benefits for Non-Intravenous Injectable Drug Therapy Services are limited to a Maximum [Lifetime] [Calendar Year] [Plan Year] [Benefit Period] [Per Cause] [Monthly] [Daily] Benefit of [$XXX] [per Covered Person]]			
[Not Covered]			
	[[Select] Participating Provider [Benefits]]	**[Participating Provider [Benefits] / Network Provider [Benefits]]**	**[Non-[Select] Participating Provider [Benefits]/ Non-Participating Provider [Benefits]/ Non-Network Provider [Benefits]]**
[[Non-Intravenous Injectable Drug Therapy Services] Maximum [Lifetime] [Calendar Year] [Plan Year] [Benefit Period] [Per Cause] [Monthly] [Daily] Benefit]	[$XXX] [per Covered Person]	[$XXX] [per Covered Person]	[$XXX] [per Covered Person]
[Benefits for [Non-Intravenous Injectable Drug Therapy Services] are payable at [0-100%] [with a [$10-$100] Copayment] when a [Designated Specialty Service Provider] is used. If a [Designated Specialty Service Provider] is not used, [Covered Charges will be [paid at the [Non-][Participating] [or] [applicable] Coinsurance] [reduced by [$1 - $3,000] [1% - 50%]][limited to [$XXX] per [Calendar] [Plan] Year] [per Covered Person] [after the Covered Person has paid any applicable Copayment, Deductible or other fees.] [These limitations will apply to all treatment rendered by a provider that is not designated as a [Designated Specialty Service Provider] regardless of whether the provider is a [Network Provider,] [Participating Provider,] [or] [Select Participating Provider].]			

BEN: 185.001.001.GE

[[**Telemedicine Services**] [**and**] [**Telehealth Services**]:]
[All services, supplies and treatments apply to the [Outpatient] [Calendar Year] [Plan Year] [Benefit Period] [Per Cause] Maximum Benefit]
[Subject to [Plan] [Outpatient] [Integrated] [Per Cause] Deductible] and Coinsurance [unless otherwise specified].]

[Benefits for [[Telemedicine Services] [and] [Telehealth Services]]are limited to a Maximum [Lifetime] [Calendar Year] [Plan Year] [Monthly] [Daily] [Benefit Period] [Per Cause] Benefit of [$1,000 - $5,000] [per Covered Person]]			
[Benefits for [[Telemedicine Services] [and] [Telehealth Services]] are limited to a Maximum Benefit of [[$XX] for each visit] [0-12 visits] [or] [up to [$XXX] each [Calendar] [Plan] [Benefit] Year] [per Covered Person].]			
[[Telemedicine Services] [and] [Telehealth Services]] Benefit Waiting Period is [[6] months] [[180] days]]]			
[Not Covered]			
[[Plan] [Integrated] [Per Cause] Deductible] [and Coinsurance] will be waived for the first [$50 - $500] [0-12 visits] of Covered Services performed [by a [Participating Provider] [Network Provider] [Retail Health Clinic]] [per] [Covered Person] [covered child] [Family] [per [Calendar Year] [Plan Year] [Benefit Period] [Per Cause] [after a [12 month] [365 day] Benefit Waiting Period][subject to a [$5 - $75] copayment].]			
	[[Select] Participating Provider [Benefits]]	**[Participating Provider [Benefits] / Network Provider [Benefits]]**	**[Non-[Select] Participating Provider [Benefits]/ Non-Participating Provider [Benefits]/ Non-Network Provider [Benefits]]**
[[Telemedicine Services] [and] [Telehealth Services]] Maximum [Lifetime] [Calendar Year] [Plan Year] [Benefit Period] [Per Cause] [Monthly] [Daily] Benefit]	[$XXX] [per Covered Person]	[$XXX] [per Covered Person]	[$XXX] [per Covered Person]
[[Telemedicine Services] [and] [Telehealth Services]]Deductible] [Individual] [Integrated] [Family]	[$XXX] [$XXX]	[$XXX] [$XXX]	[$XXX] [$XXX]
The [[Telemedicine Services] [and] [Telehealth Services]] Deductible] does [not] apply to the Plan Deductible or Total Out-of-Pocket Limits.			
[[Non-Participating] [Non-network] Provider Deductible is in addition to the [Participating] [Network] Provider Deductible.]			
[Once [[2] or more Covered Persons have collectively met] the maximum Family Deductible [has been met], no additional Deductible will be taken during the [Calendar Year] [Plan Year] [Benefit Period] [Time Period].]			
[Access] [Fee]	[None / $XXX per [[Telemedicine Services] [and] [Telehealth Services]]	[None / $XXX per [[Telemedicine Services] [and] [Telehealth Services]]	[None / $XXX per [[Telemedicine Services] [and] [Telehealth Services]]
[Copayment]	[None / $XXX per [[Telemedicine Services] [and] [Telehealth Services]]	[None / $XXX per [[Telemedicine Services] [and] [Telehealth Services]]	[None / $XXX per [[Telemedicine Services] [and] [Telehealth Services]]
[[Telemedicine Services] [and] [Telehealth Services]][Coinsurance] [Tier [1]]	[0% - 100% [until the [[Telemedicine Services] [and] [Telehealth Services]] [Tier [1]] Out-of-Pocket Limits are satisfied; [then Tier [2];] [100% thereafter.]]	[0% - 100% [until the [[Telemedicine Services] [and] [Telehealth Services] [Tier [1]] Out-of-Pocket Limits are satisfied; [then Tier [2];] [100% thereafter.]]	[0% - 100% [until the [[Telemedicine Services] [and] [Telehealth Services] [Tier [1]] Out-of-Pocket Limits are satisfied; [then Tier [2];] [100% thereafter.]]

[Tier [1]] [[Telemedicine Services] [and] [Telehealth Services]][Out-of-Pocket Limit][each [Calendar Year] [Benefit Period] [Time Period] [Plan Year]] [Individual]	[$0 - $25,000 / Not applicable]	[$0 - $25,000 / Not applicable]	[$0 - $25,000 / an additional $0 - $10,000]
[Family]	[$0 - $75,000 / Not applicable]	[$0 - $75,000 / Not applicable]	[$0 - $75,000 / an additional $0 - $30,000]
[[Telemedicine Services] [and] [Telehealth Services]] [Coinsurance] [Tier [2]]	[0% - 100% [until the [[Telemedicine Services] [and] [Telehealth Services] [Tier [2]] Out-of-Pocket Limits are satisfied; [then Tier [X];] [100% thereafter.]]	[0% - 100% [until the [[Telemedicine Services] [and] [Telehealth Services] [Tier [2]] Out-of-Pocket Limits are satisfied; [then Tier [X];] [100% thereafter.]]	[0% - 100% [until the [[Telemedicine Services] [and] [Telehealth Services]] [Tier [2]] Out-of-Pocket Limits are satisfied; [then Tier [X];] [100% thereafter.]]
[Tier [2]] [[Telemedicine Services] [and] [Telehealth Services]][Out-of-Pocket Limit] [each [Calendar Year] [Benefit Period] [Time Period] [Plan Year]] [Individual]	[$0 - $25,000 / Not applicable]	[$0 - $25,000 / Not applicable]	[$0 - $25,000 / an additional $0 - $10,000]
[Family]	[$0 - $75,000 / Not applicable]	[$0 - $75,000 / Not applicable]	[$0 - $75,000 / an additional $0 - $30,000]
[[Telemedicine Services] [and] [Telehealth Services]] [Coinsurance] [Tier [X]]	[0% - 100% [until the [[Telemedicine Services] [and] [Telehealth Services] [Tier [X]] Out-of-Pocket Limits are satisfied;] [then Tier [X + [1]];] [100% thereafter.]]	[0% - 100% [until the [[Telemedicine Services] [and] [Telehealth Services] [Tier [X]] Out-of-Pocket Limits are satisfied;] [then Tier [X + [1]];] [100% thereafter.]]	[0% - 100% [until the [[Telemedicine Services] [and] [Telehealth Services] [Tier [X]] Out-of-Pocket Limits are satisfied;] [then Tier [X + [1]];] [100% thereafter.]]
[Tier [X]] [[Telemedicine Services] [and] [Telehealth Services]][Out-of-Pocket Limit][each [Calendar Year] [Benefit Period] [Time Period] [Plan Year]] [Individual]	[$0 - $25,000 / Not applicable]	[$0 - $25,000 / Not applicable]	[$0 - $25,000 / an additional $0 - $10,000]
[Family]	[$0 - $75,000 / Not applicable]	[$0 - $75,000 / Not applicable]	[$0 - $75,000 / an additional $0 - $30,000]
[[Telemedicine Services] [and]			

[Telehealth Services]] Out-of-Pocket Limits] [Individual] [Family]	[$XXX] [$XXX]	[$XXX] [$XXX]	[$XXX] [$XXX]
[Benefits for [Telemedicine Services] [and] [Telehealth Services] are payable at [0-100%] [with a [$10-$100] Copayment] when a [Designated Specialty Service Provider] is used. If a [Designated Specialty Service Provider] is not used, [Covered Charges will be [paid at the [Non-][Participating] [or] [applicable] Coinsurance] [reduced by [$1 - $3,000] [1% - 50%]][limited to [$XXX] per [Calendar] [Plan] Year] [per Covered Person] [after the Covered Person has paid any applicable Copayment, Deductible or other fees.] [These limitations will apply to all treatment rendered by a provider that is not designated as a [Designated Specialty Service Provider] regardless of whether the provider is a [Network Provider,] [Participating Provider,] [or] [Select Participating Provider].]			

BEN: 190.001.001.GE

[[**Out of Network**][**Travel Benefit**]:]			
[All services, supplies and treatments apply to the [Outpatient] [Calendar Year] [Plan Year] [Benefit Period] [Per Cause] Maximum Benefit]			
[Subject to [Plan] [Inpatient][and] [and][Outpatient] [Integrated] [Per Cause] Deductible] and [Plan] [and][Inpatient][and][Outpatient]Coinsurance [unless otherwise specified]]			
[Benefits are limited to [2] [Network][Participating] [Provider] [Office Visits] and [up to] [$250 - $1,000] for [Diagnostic Imaging Services] [and] [Laboratory Services]]			
[Out of Network] [Travel Benefit Waiting Period is [[60] days].]			
[Not Covered]			
	[Primary Care Physician / [Select] Participating Provider [Benefits]]	**[Participating Provider [Benefits] / Network Provider [Benefits]]**	**[Non-[Select] Participating Provider [Benefits]/ Non-Participating Provider [Benefits]/ Non-Network Provider [Benefits]]**
[Out of Network] [Travel Benefit] Maximum [Lifetime] [Calendar Year] [Plan Year] [Benefit Period] [Per Cause] [Monthly] [Daily] Benefit]	[$XXX] [per Covered Person]	[$XXX] [per Covered Person]	[$XXX] [per Covered Person]
[Out of Network] [Travel Benefit Deductible] [Individual] [Integrated] [Family]	[$XXX] [$XXX]	[$XXX] [$XXX]	[$XXX] [$XXX]
[The [Out of Network] Travel Benefit Deductible] does [not] apply to the Plan Deductible or Total Out-of-Pocket Limits.]			
[[Non-Participating] [Non-network] Provider Deductible is in addition to the [Participating] [Network] Provider Deductible.]			
[Once [[2] or more Covered Persons have collectively met] the maximum Family Deductible [has been met], no additional Deductible will be taken during the [Calendar Year] [Plan Year] [Benefit Period] [Time Period].]			
[Access] [Fee]	[None / $XXX per Travel Benefit Service]	[None / $XXX per Travel Benefit Service]	[None / $XXX per Travel Benefit Service]
[Copayment]	[None / $XXX per Travel Benefit Service]	[None / $XXX per Travel Benefit Service]	[None / $XXX per Travel Benefit Service]

[Out of Network] [Travel Benefit] [Coinsurance] [Tier [1]]	[0% - 100% [until the [Out of Network] [Travel Benefit] [Tier [1]] Out-of-Pocket Limits are satisfied; [then Tier [2];] [100% thereafter.]]	[0% - 100% [until the [Out of Network] [Travel Benefit] [Tier [1]] Out-of-Pocket Limits are satisfied; [then Tier [2];] [100% thereafter.]]	[0% - 100% [until the [Out of Network] [Travel Benefit] [Tier [1]] Out-of-Pocket Limits are satisfied; [then Tier [2];] [100% thereafter.]]
[Tier [1]] [Out of Network] [Travel Benefit] Out-of-Pocket Limit [each [Calendar Year] [Benefit Period] [Time Period] [Plan Year]]			
[Individual]	[$0 - $25,000 / Not applicable]	[$0 - $25,000 / Not applicable]	[$0 - $25,000 / an additional $0 - $10,000]
[Family]	[$0 - $75,000 / Not applicable]	[$0 - $75,000 / Not applicable]	[$0 - $75,000 / an additional $0 - $30,000]
[Out of Network] [Travel Benefit] [Coinsurance] [Tier [2]]	[0% - 100% [until the [Out of Network] [Travel Benefit] [Tier [2]] Out-of-Pocket Limits are satisfied; [then Tier [X];] [100% thereafter.]]	[0% - 100% [until the [Out of Network] [Travel Benefit] [Tier [2]] Out-of-Pocket Limits are satisfied; [then Tier [X];] [100% thereafter.]]	[0% - 100% [until the [Out of Network] [Travel Benefit] [Tier [2]] Out-of-Pocket Limits are satisfied; [then Tier [X];] [100% thereafter.]]
[Tier [2]] [Out of Network] [Travel Benefit] Out-of-Pocket Limit [each [Calendar Year] [Benefit Period] [Time Period] [Plan Year]]			
[Individual]	[$0 - $25,000 / Not applicable]	[$0 - $25,000 / Not applicable]	[$0 - $25,000 / an additional $0 - $10,000]
[Family]	[$0 - $75,000 / Not applicable]	[$0 - $75,000 / Not applicable]	[$0 - $75,000 / an additional $0 - $30,000]
[Out of Network] [Travel Benefit] [Coinsurance] [Tier [X]]	[0% - 100% [until the [Out of Network] [Travel Benefit] [Tier [X]] Out-of-Pocket Limits are satisfied;] [then Tier [X + [1]];] [100% thereafter.]]	[0% - 100% [until the [Out of Network] [Travel Benefit] [Tier [X]] Out-of-Pocket Limits are satisfied;] [then Tier [X + [1]];] [100% thereafter.]]	[0% - 100% [until the [Out of Network] [Travel Benefit] [Tier [X]] Out-of-Pocket Limits are satisfied;] [then Tier [X + [1]];] [100% thereafter.]]
[Tier [X]] [Out of Network] [Travel Benefit] Out-of-Pocket Limit [each [Calendar Year] [Benefit Period] [Time Period] [Plan Year]]			
[Individual]	[$0 - $25,000 / Not applicable]	[$0 - $25,000 / Not applicable]	[$0 - $25,000 / an additional $0 - $10,000]
[Family]	[$0 - $75,000 / Not	[$0 - $75,000 / Not	[$0 - $75,000 / an

	applicable]	applicable]	additional $0 - $30,000]
[[Out of Network] [Travel Benefit] Out-of-Pocket Limits] [Individual] [Family]	 [$XXX] [$XXX]	 [$XXX] [$XXX]	 [$XXX] [$XXX]

BEN: 195.001.001.GE

[**Choice of Network Service Area Benefit**:]
[All services, supplies and treatments apply to the [Plan] [and][Outpatient] [and] [Inpatient] [and] [Calendar Year] [Plan Year] [Benefit Period] Maximum Benefit]]
[Subject to [Plan] [and][Outpatient] [and] [Inpatient][and][International Coverage][and] [Integrated] [Per Cause] Deductible] and [Plan] [and][Outpatient] [and] [Inpatient]Coinsurance [unless otherwise specified].]
[Not Covered]

BEN: 200.001.GE

[Nationwide Network Benefit:]
[All services, supplies and treatments apply to the [Plan] [and][Outpatient] [and] [Inpatient] [and] [Calendar Year] [Plan Year] [Benefit Period] Maximum Benefit]]
[Subject to [Plan] [and][Outpatient] [and] [Inpatient][and] [Integrated] [Per Cause] Deductible] and [Plan] [and][Outpatient] [International Coverage] [and] [Inpatient]Coinsurance [unless otherwise specified].]
[Not Covered]

BEN: 205.001.GE

[**International Coverage**:]
[All services, supplies and treatments apply to the [Plan] [and][Outpatient] [and] [Inpatient] [and][International Coverage] [Calendar Year] [Plan Year] [Benefit Period] Maximum Benefit]]
[Subject to [Plan] [and][Outpatient] [and] [Inpatient][and][International Coverage][and] [Integrated] [Per Cause] Deductible] and [Plan] [and][Outpatient] [International Coverage] [and] [Inpatient]Coinsurance [unless otherwise specified].]
[International Coverage Benefits are limited to a Maximum of [$XXX][for services rendered outside the United States of America]].
[International Coverage is subject to the International Coverage Deductible [and Coinsurance] then Covered Charges are paid at [100%] up to [$XX], Covered Charges are then subject the [Plan] [and][Outpatient] [and] [Inpatient] [Per Cause] Deductible] and [Plan] [and][Outpatient] [and] [Inpatient]Coinsurance.]]
[International Coverage Benefit Waiting Period is [90 days].]
[Not Covered]

	[Primary Care Physician / [Select] Participating Provider [Benefits]]	**[Participating Provider [Benefits] / Network Provider [Benefits]]**	**[Non-[Select] Participating Provider [Benefits]/ Non-Participating Provider [Benefits]/ Non-Network Provider [Benefits]]**
[[International Coverage] Maximum[Lifetime] [Calendar Year] [Plan Year] [Monthly] [Daily]	[$XXX] [Per Covered Person]	[$XXX] [Per Covered Person]	[$XXX] [Per Covered Person]

Benefit]			
[[International Coverage] Maximum [Lifetime] [Calendar Year] [Plan Year] [Monthly] [Daily] Benefit] [due to an [Accidental Injury] [Injury] [or] [underlying Sickness]]	[$XXX] [Per Covered Person]	[$XXX] [Per Covered Person]	[$XXX] [Per Covered Person]
[International Coverage Deductible] [Individual] [Integrated] [Family]	[$XXX] [$XXX]	[$XXX] [$XXX]	[$XXX] [$XXX]
[The [International Covered Deductible] does [not] apply to the Plan Deductible or Total Out-of-Pocket Limits.]			
[[Non-Participating] [Non-network] Provider Deductible is in addition to the [Participating] [Network] Provider Deductible.]			
[Once [[2] or more Covered Persons have collectively met] the maximum Family Deductible [has been met], no additional Deductible will be taken during the [Calendar Year] [Plan Year] [Benefit Period] [Time Period].]			
[Access] [Fee]	[None / $XXX per International Coverage Service]	[None / $XXX per International Coverage Service]	[None / $XXX per International Coverage Service]
[Copayment]	[None / $XXX per International Coverage Service]	[None / $XXX per International Coverage Service]	[None / $XXX per International Coverage Service]
[International Coverage] [Coinsurance] [Tier [1]]	[0% - 100% [until the [International Coverage] [Tier [1]] Out-of-Pocket Limits are satisfied; [then Tier [2];] [100% thereafter.]]	[0% - 100% [until the [International Coverage] [Tier [1]] Out-of-Pocket Limits are satisfied; [then Tier [2];] [100% thereafter.]]	[0% - 100% [until the [International Coverage] [Tier [1]] Out-of-Pocket Limits are satisfied; [then Tier [2];] [100% thereafter.]]
[Tier [1]] [International Coverage] [Out-of-Pocket Limit] [each [Calendar Year] [Benefit Period] [Time Period] [Plan Year]] [Individual] [Family]	[$0 - $25,000 / Not applicable] [$0 - $75,000 / Not applicable]	[$0 - $25,000 / Not applicable] [$0 - $75,000 / Not applicable]	[$0 - $25,000 / an additional $0 - $10,000] [$0 - $75,000 / an additional $0 - $30,000]
[International Coverage] [Coinsurance] [Tier [2]]	[0% - 100% [until the [International Coverage] [Tier [2]] Out-of-Pocket Limits are satisfied; [then Tier [X];] [100% thereafter.]]	[0% - 100% [until the [International Coverage] [Tier [2]] Out-of-Pocket Limits are satisfied; [then Tier [X];] [100% thereafter.]]	[0% - 100% [until the [International Coverage] [Tier [2]] Out-of-Pocket Limits are satisfied; [then Tier [X];] [100% thereafter.]]
[Tier [2]] [International Coverage] [Out-of-Pocket Limit] [each [Calendar Year] [Benefit Period] [Time Period] [Plan Year]] [Individual]	[$0 - $25,000 / Not applicable]	[$0 - $25,000 / Not applicable]	[$0 - $25,000 / an additional

[Family]	[$0 - $75,000 / Not applicable]	[$0 - $75,000 / Not applicable]	$0 - $10,000] [$0 - $75,000 / an additional $0 - $30,000]
[International Coverage] [Coinsurance] [Tier [X]]	[0% - 100% [until the [International Coverage] [Tier [X]] Out-of-Pocket Limits are satisfied;] [then Tier [X + [1]];] [100% thereafter.]]	[0% - 100% [until the [International Coverage] [Tier [X]] Out-of-Pocket Limits are satisfied;] [then Tier [X + [1]];] [100% thereafter.]]	[0% - 100% [until the [International Coverage] [Tier [X]] Out-of-Pocket Limits are satisfied;] [then Tier [X + [1]];] [100% thereafter.]]
[Tier [X]] [International Coverage] [Out-of-Pocket Limit] [each [Calendar Year] [Benefit Period] [Time Period] [Plan Year]]			
[Individual]	[$0 - $25,000 / Not applicable]	[$0 - $25,000 / Not applicable]	[$0 - $25,000 / an additional $0 - $10,000]
[Family]	[$0 - $75,000 / Not applicable]	[$0 - $75,000 / Not applicable]	[$0 - $75,000 / an additional $0 - $30,000]
[[International Coverage] [Out-of-Pocket Limits]]			
[Individual]	[$XXX]	[$XXX]	[$XXX]
[Family]	[$XXX]	[$XXX]	[$XXX]

BEN: 210.001.001.GE

[**Travel Benefit**:]			
[All services, supplies and treatments apply to the [Outpatient] [Calendar Year] [Plan Year] [Benefit Period] [Per Cause] Maximum Benefit]			
[Subject to [Plan] [Inpatient][and] [and][Outpatient] [Integrated] [Per Cause] Deductible] and [Plan] [and][Inpatient][and][Outpatient]Coinsurance [unless otherwise specified]]			
[Benefits are limited to [2] [Network][Participating] [Provider] [Office Visits] and [up to] [$500] for [Diagnostic Imaging Services] [and] [Laboratory Services]]			
[Travel Benefit Waiting Period is [[60] days].]			
[Not Covered]			
	[Primary Care Physician / [Select] Participating Provider [Benefits]]	**[Participating Provider [Benefits] / Network Provider [Benefits]]**	**[Non-[Select] Participating Provider [Benefits]/ Non-Participating Provider [Benefits]/ Non-Network Provider [Benefits]]**
[Travel Benefit] Maximum [Lifetime] [Calendar Year] [Plan Year] [Benefit Period] [Per Cause] [Monthly] [Daily] Benefit]	[$XXX] [per Covered Person]	[$XXX] [per Covered Person]	[$XXX] [per Covered Person]
[Travel Benefit Deductible]			

[Individual] [Integrated] [Family]	[$XXX] [$XXX]	[$XXX] [$XXX]	[$XXX] [$XXX]
[The Travel Benefit Deductible] does [not] apply to the Plan Deductible or Total Out-of-Pocket Limits.]			
[[Non-Participating] [Non-network] Provider Deductible is in addition to the [Participating] [Network] Provider Deductible.]			
[Once [[2] or more Covered Persons have collectively met] the maximum Family Deductible [has been met], no additional Deductible will be taken during the [Calendar Year] [Plan Year] [Benefit Period] [Time Period].]			
[Access] [Fee]	[None / $XXX per Travel Benefit Service]	[None / $XXX per Travel Benefit Service]	[None / $XXX per Travel Benefit Service]
[Copayment]	[None / $XXX per Travel Benefit Service]	[None / $XXX per Travel Benefit Service]	[None / $XXX per Travel Benefit Service]
[Travel Benefit] [Coinsurance] [Tier [1]]	[0% - 100% [until the [Travel Benefit] [Tier [1]] Out-of-Pocket Limits are satisfied; [then Tier [2];] [100% thereafter.]]	[0% - 100% [until the [Travel Benefit] [Tier [1]] Out-of-Pocket Limits are satisfied; [then Tier [2];] [100% thereafter.]]	[0% - 100% [until the [Travel Benefit] [Tier [1]] Out-of-Pocket Limits are satisfied; [then Tier [2];] [100% thereafter.]]
[Tier [1]] [Travel Benefit] Out-of-Pocket Limit [each [Calendar Year] [Benefit Period] [Time Period] [Plan Year]] [Individual] [Family]	[$0 - $25,000 / Not applicable] [$0 - $75,000 / Not applicable]	[$0 - $25,000 / Not applicable] [$0 - $75,000 / Not applicable]	[$0 - $25,000 / an additional $0 - $10,000] [$0 - $75,000 / an additional $0 - $30,000]
[[Travel Benefit] [Coinsurance] [Tier [2]]	[0% - 100% [until the [Travel Benefit] [Tier [2]] Out-of-Pocket Limits are satisfied; [then Tier [X];] [100% thereafter.]]	[0% - 100% [until the [Travel Benefit] [Tier [2]] Out-of-Pocket Limits are satisfied; [then Tier [X];] [100% thereafter.]]	[0% - 100% [until the [Travel Benefit] [Tier [2]] Out-of-Pocket Limits are satisfied; [then Tier [X];] [100% thereafter.]]
[Tier [2]] [Travel Benefit] Out-of-Pocket Limit [each [Calendar Year] [Benefit Period] [Time Period] [Plan Year]] [Individual] [Family]	[$0 - $25,000 / Not applicable] [$0 - $75,000 / Not applicable]	[$0 - $25,000 / Not applicable] [$0 - $75,000 / Not applicable]	[$0 - $25,000 / an additional $0 - $10,000] [$0 - $75,000 / an additional $0 - $30,000]
[Travel Benefit] [Coinsurance] [Tier [X]]	[0% - 100% [until the [Travel Benefit] [Tier [X]] Out-of-Pocket Limits are satisfied;] [then Tier [X + [1]];] [100% thereafter.]]	[0% - 100% [until the [Travel Benefit] [Tier [X]] Out-of-Pocket Limits are satisfied;] [then Tier [X + [1]];] [100% thereafter.]]	[0% - 100% [until the [Travel Benefit] [Tier [X]] Out-of-Pocket Limits are satisfied;] [then Tier [X + [1]];] [100% thereafter.]]

[Tier [X]] [Travel Benefit] Out-of-Pocket Limit [each [Calendar Year] [Benefit Period] [Time Period] [Plan Year]] [Individual]	[$0 - $25,000 / Not applicable]	[$0 - $25,000 / Not applicable]	[$0 - $25,000 / an additional $0 - $10,000]
[Family]	[$0 - $75,000 / Not applicable]	[$0 - $75,000 / Not applicable]	[$0 - $75,000 / an additional $0 - $30,000]
[Travel Benefit] Out-of-Pocket Limits] [Individual]	[$XXX]	[$XXX]	[$XXX]
[Family]	[$XXX]	[$XXX]	[$XXX]

BEN: 215.001.001.GE

[**Repatriation Services**:]			
[All services, supplies and treatments apply to the [Outpatient] [and] [Calendar Year] [and] [Plan Year] [Benefit Period] [Per Cause] Maximum Benefit]			
[Subject to [Plan] [and] [Outpatient] [Integrated] [Per Cause] Deductible] and [Plan] [and] [Outpatient] Coinsurance [unless otherwise specified]]			
[Benefits for Repatriation Services are limited to a Maximum [Lifetime] [Calendar Year] [Plan Year] [Benefit Period] [Per Cause] [Monthly] [Daily] Benefit of [$XXX]]			
[Benefits for Repatriation Services are limited to a Maximum Benefit of [[$10,000] [per Covered Person].]			
[Repatriation Services Benefit Waiting Period is [[12] [months].]			
[Not Covered]			
	[]Select] Participating Provider Benefits]	**[Participating Provider Benefits / Network Provider Benefits]**	**[Non-[Select] Participating Provider Benefits/ Non-Participating Provider Benefits/ Non-Network Provider Benefits]**
[Repatriation Services]] Maximum [Lifetime] [Calendar Year] [Plan Year] [Benefit Period] [Per Cause] [Monthly] [Daily] Benefit]	[$XXX] [per Covered Person]	[$XXX] [per Covered Person]	[$XXX] [per Covered Person]
[Repatriation Services Deductible] [Individual]	[$XXX]	[$XXX]	[$XXX]
[Integrated] [Family]	[$XXX]	[$XXX]	[$XXX]
[The [Repatriation Services Deductible] does [not] apply to the Plan Deductible or Total Out-of-Pocket Limits.]			
[Once [[2] or more Covered Persons have collectively met] the maximum Family Deductible [[has been met], no additional Deductible will be taken during the [Calendar Year] [Plan Year] [Benefit Period] [Time Period].]			
[Copayment]	[None / $XXX per Repatriation Service]	[None / $XXX per Repatriation Service]	[None / $XXX per Repatriation Service]
[[Repatriation Services] [Coinsurance] [Tier [1]]	[0% - 100% [until the [Repatriation Services] [Tier [1]] Out-of-Pocket Limits are satisfied; [then Tier [2];] [100% thereafter.]]	[0% - 100% [until the [Repatriation Services] [Tier [1]] Out-of-Pocket Limits are satisfied; [then Tier [2];] [100%	[0% - 100% [until the [Repatriation Services] [Tier [1]] Out-of-Pocket Limits are satisfied; [then Tier [2];] [100% thereafter.]]

		thereafter.]]	
[Tier [1]] [[Repatriation Services]Out-of-Pocket Limit [each [Calendar Year] [Benefit Period] [Time Period] [Plan Year]] [Individual]	[$0 - $25,000 / Not applicable]	[$0 - $25,000 / Not applicable]	[$0 - $25,000 / an additional $0 - $10,000]
[Family]	[$0 - $75,000 / Not applicable]	[$0 - $75,000 / Not applicable]	[$0 - $75,000 / an additional $0 - $30,000]
[[Repatriation Services] [Coinsurance] [Tier [2]]	[0% - 100% [until the [Repatriation Services] [Tier [2]] Out-of-Pocket Limits are satisfied; [then Tier [X];] [100% thereafter.]]	[0% - 100% [until the [Repatriation Services] [Tier [2]] Out-of-Pocket Limits are satisfied; [then Tier [X];] [100% thereafter.]]	[0% - 100% [until the [Repatriation Services] [Tier [2]] Out-of-Pocket Limits are satisfied; [then Tier [X];] [100% thereafter.]]
[Tier [2]] [[Repatriation Services]Out-of-Pocket Limit [each [Calendar Year] [Benefit Period] [Time Period] [Plan Year]] [Individual]	[$0 - $25,000 / Not applicable]	[$0 - $25,000 / Not applicable]	[$0 - $25,000 / an additional $0 - $10,000]
[Family]	[$0 - $75,000 / Not applicable]	[$0 - $75,000 / Not applicable]	[$0 - $75,000 / an additional $0 - $30,000]
[[Repatriation Services] [Coinsurance] [Tier [X]]	[0% - 100% [until the [Repatriation Services] [Tier [X]] Out-of-Pocket Limits are satisfied;] [then Tier [X + [1]];] [100% thereafter.]]	[0% - 100% [until the [Repatriation Services] [Tier [X]] Out-of-Pocket Limits are satisfied;] [then Tier [X + [1]];] [100% thereafter.]]	[0% - 100% [until the [Repatriation Services] [Tier [X]] Out-of-Pocket Limits are satisfied;] [then Tier [X + [1]];] [100% thereafter.]]
[Tier [X]] [[Repatriation Services]Out-of-Pocket Limit [each [Calendar Year] [Benefit Period] [Time Period] [Plan Year]] [Individual]	[$0 - $25,000 / Not applicable]	[$0 - $25,000 / Not applicable]	[$0 - $25,000 / an additional $0 - $10,000]
[Family]	[$0 - $75,000 / Not applicable]	[$0 - $75,000 / Not applicable]	[$0 - $75,000 / an additional $0 - $30,000]
[[Repatriation Services] [Out-of-Pocket Limits]] [Individual]	[$XXX]	[$XXX]	[$XXX]

[Family]	[$XXX]	[$XXX]	[$XXX]
[Benefits for [Repatriation Services] are payable at [0%-100%] [with a [$10 - $100] Copayment] when a [Designated Specialty Service Provider] is used. If a [Designated Specialty Service Provider] is not used, [Covered Charges will be [paid at the [Non-][Participating] [or] [applicable] Coinsurance] [reduced by [$1 - $3,000] [1%-50%]] [limited to [$XXX] per [Calendar] [Plan] Year] [per Covered Person] [after the Covered Person has paid any applicable Copayment, Deductible or other fees.] [These limitations will apply to all treatment rendered by a provider that is not designated as a [Designated Specialty Service Provider] regardless of whether the provider is a [Network Provider,] [Participating Provider,] [or] [Select Participating Provider].]			

BEN: 275.001.GE

[**Medical Evacuation Services**:]			
[All services, supplies and treatments apply to the [Outpatient] [and] [Calendar Year] [and] [Plan Year] [Benefit Period] [Per Cause] Maximum Benefit]			
[Subject to [Plan] [and] [Outpatient] [Integrated] [Per Cause] Deductible] and [Plan] [and] [Outpatient] Coinsurance [unless otherwise specified]]			
[Benefits for Medical Evacuation Services are limited to a Maximum [Lifetime] [Calendar Year] [Plan Year] [Benefit Period] [Per Cause] [Monthly] [Daily] Benefit of [$XXX]]			
[Benefits for Medical Evacuation Services are limited to a Maximum Benefit of [[$10,000] [per Covered Person].]			
[Medical Evacuation Services Benefit Waiting Period is [[12] [months].]			
[Not Covered]			
	[[Select] Participating Provider Benefits]	**[Participating Provider Benefits / Network Provider Benefits]**	**[Non-[Select] Participating Provider Benefits/ Non-Participating Provider Benefits/ Non-Network Provider Benefits]**
[Medical Evacuation Services]] Maximum [Lifetime] [Calendar Year] [Plan Year] [Benefit Period] [Per Cause] [Monthly] [Daily] Benefit]	[$XXX] [per Covered Person]	[$XXX] [per Covered Person]	[$XXX] [per Covered Person]
[Medical Evacuation Services Deductible] [Individual] [Integrated] [Family]	[$XXX] [$XXX]	[$XXX] [$XXX]	[$XXX] [$XXX]
[The [Medical Evacuation Services Deductible] does [not] apply to the Plan Deductible or Total Out-of-Pocket Limits.]			
[Once [[2] or more Covered Persons have collectively met] the maximum Family Deductible [[has been met], no additional Deductible will be taken during the [Calendar Year] [Plan Year] [Benefit Period] [Time Period].]			
[Copayment]	[None / $XXX per Medical Evacuation Service]	[None / $XXX per Medical Evacuation Service]	[None / $XXX per Medical Evacuation Service]
[[Medical Evacuation Services] [Coinsurance] [Tier [1]]	[0% - 100% [until the [Medical Evacuation Services] [Tier [1]] Out-of-Pocket Limits are satisfied; [then Tier [2];] [100% thereafter.]]	[0% - 100% [until the [Medical Evacuation Services] [Tier [1]] Out-of-Pocket Limits are satisfied; [then Tier [2];] [100% thereafter.]]	[0% - 100% [until the [Medical Evacuation Services] [Tier [1]] Out-of-Pocket Limits are satisfied; [then Tier [2];] [100% thereafter.]]

[Tier [1]] [[Medical Evacuation Services]Out-of-Pocket Limit [each [Calendar Year] [Benefit Period] [Time Period] [Plan Year]] [Individual]	[$0 - $25,000 / Not applicable]	[$0 - $25,000 / Not applicable]	[$0 - $25,000 / an additional $0 - $10,000]
[Family]	[$0 - $75,000 / Not applicable]	[$0 - $75,000 / Not applicable]	[$0 - $75,000 / an additional $0 - $30,000]
[[Medical Evacuation Services] [Coinsurance] [Tier [2]]	[0% - 100% [until the [Medical Evacuation Services] [Tier [2]] Out-of-Pocket Limits are satisfied; [then Tier [X];] [100% thereafter.]]	[0% - 100% [until the [Medical Evacuation Services] [Tier [2]] Out-of-Pocket Limits are satisfied; [then Tier [X];] [100% thereafter.]]	[0% - 100% [until the [Medical Evacuation Services] [Tier [2]] Out-of-Pocket Limits are satisfied; [then Tier [X];] [100% thereafter.]]
[Tier [2]] [[Medical Evacuation Services]Out-of-Pocket Limit [each [Calendar Year] [Benefit Period] [Time Period] [Plan Year]] [Individual]	[$0 - $25,000 / Not applicable]	[$0 - $25,000 / Not applicable]	[$0 - $25,000 / an additional $0 - $10,000]
[Family]	[$0 - $75,000 / Not applicable]	[$0 - $75,000 / Not applicable]	[$0 - $75,000 / an additional $0 - $30,000]
[[Medical Evacuation Services] [Coinsurance] [Tier [X]]	[0% - 100% [until the [Medical Evacuation Services] [Tier [X]] Out-of-Pocket Limits are satisfied;] [then Tier [X + [1]];] [100% thereafter.]]	[0% - 100% [until the [Medical Evacuation Services] [Tier [X]] Out-of-Pocket Limits are satisfied;] [then Tier [X + [1]];] [100% thereafter.]]	[0% - 100% [until the [Medical Evacuation Services] [Tier [X]] Out-of-Pocket Limits are satisfied;] [then Tier [X + [1]];] [100% thereafter.]]
[Tier [X]] [[Medical Evacuation Services]Out-of-Pocket Limit [each [Calendar Year] [Benefit Period] [Time Period] [Plan Year]] [Individual]	[$0 - $25,000 / Not applicable]	[$0 - $25,000 / Not applicable]	[$0 - $25,000 / an additional $0 - $10,000]
[Family]	[$0 - $75,000 / Not applicable]	[$0 - $75,000 / Not applicable]	[$0 - $75,000 / an additional $0 - $30,000]
[[Medical Evacuation Services] [Out-of-Pocket Limits]] [Individual]	[$XXX]	[$XXX]	[$XXX]
[Family]	[$XXX]	[$XXX]	[$XXX]

[Benefits for [Medical Evacuation Services] are payable at [0%-100%] [with a [$10 - $100] Copayment] when a [Designated Specialty Service Provider] is used. If a [Designated Specialty Service Provider] is not used, [Covered Charges will be [paid at the [Non-][Participating] [or] [applicable] Coinsurance] [reduced by [$1 - $3,000] [1%-50%]] [limited to [$XXX] per [Calendar] [Plan] Year] [per Covered Person] [after the Covered Person has paid any applicable Copayment, Deductible or other fees.] [These limitations will apply to all treatment rendered by a provider that is not designated as a [Designated Specialty Service Provider] regardless of whether the provider is a [Network Provider,] [Participating Provider,] [or] [Select Participating Provider].]

BEN: 280.001.GE

[**Outpatient**] **Prescription Drug Benefits**:]

[All services, supplies and treatments apply to the [Outpatient] [and] [Calendar Year] [Plan Year] Maximum Benefit]

[Subject to [Plan][and][Outpatient][Integrated] [Per Cause] Deductible] and [Plan][and][Outpatient] Coinsurance [unless otherwise specified]]

[Benefits for Prescription Drugs are limited to a Maximum [Calendar Year] [Plan Year] [Monthly] [Daily] Benefit of [$1,000 - $10,000] [per] [Covered Person] [Covered Child] [$2,000 - $20,000] [per Family]]

[Benefits for Prescription Drugs are limited to a Maximum [Lifetime] [Benefit Period] Benefit of [$1,000 -$10,000] [per] [Covered Person] [Covered Child] [$2,000 - $20,000] [per Family]]

[For Prescription Drugs and medicines Covered Charges are limited to [$2,000] per [Calendar Year][Plan Year][Benefit Period] [Time Period] for:

- [Legend drugs and medicines that by Federal law can only be obtained with a prescription;]
- [Injectable insulin with a prescription;]
- [Disposable insulin syringes, and disposable blood/urine, glucose/acetone testing agents or lancets.]]

[[$20] maximum per [Outpatient] Prescription Drug[, limited to $1,000 - $5,000] [limited to [XX] prescriptions] Maximum Benefit per [Calendar Year][Plan Year][Benefit Period] [Time Period] [Month][for] [Anti-Infective Prescription Drugs] [per Covered Person] [Per Covered Child]]

[[Outpatient] Prescription Drugs Benefit Waiting Period is [[12] months] [[365] days].]

[Outpatient] Prescription Drugs Benefits do [not] apply to the [Plan][Inpatient][Outpatient] Out of Pocket Limits]

[Not Covered]

[Participating Pharmacy Plan:] [PBM]

[Prescription Drug [Calendar Year] [Plan Year] [Benefit Period] [Per Cause] Maximum Benefit] [[$XXX] per [Covered Person] [Covered Child]]:
[[Preferred][Generic] Drug: [$100 - $5]]
[[Non-preferred][Generic] Drug: [$100 - $5,000]]
[[Preferred] Brand Name Drug: [$100 - $5,000]]
[[Non-Preferred] Brand Name Drug: [$100 - $5,000]]

[Prescription Drug [Lifetime] Maximum Benefit] [[$XXX] [per Covered Person] [Covered Child]]:
[[Preferred][Generic] Drug: [$100 - $5,000]]
[[Non-preferred][Generic] Drug: [$100 - $5,000]]
[[Preferred] Brand Name Drug: [$100 - $5,000]]
[[Non-Preferred] Brand Name Drug: [$100 - $5,000]]

[Prescription Drug [Individual] [Integrated] Deductible:] [$0 - $9750]
[[Preferred][Generic] Drug: [$0 - $9750]]
[[Non-Preferred] Generic Drug: [$0 - $9750]]
[[Preferred] Brand Name Drug: [$0 - $9750]]
[[Non-Preferred] Brand Name Drug: [$0 - $9750]]
[Subject to Plan [Individual] Deductible and Coinsurance.]

[Prescription Drug [Integrated] Family Maximum Deductible:] [$0 - $9750]
[[Preferred][Generic] Drug: [$0 - $9750]]
[[Non-preferred] Generic Drug: [$0 - $9750]]
[[Preferred] Brand Name Drug: [$0 - $9750]]
[[Non-Preferred] Brand Name Drug: [$0 - $9750]]
[Subject to [Integrated] [Family] Deductible and Coinsurance.]

[Prescription Drug [Deductible] [per Covered Person] [Covered Child]:] [$0 - $9750]

[**Designated Specialty Pharmacy Provider**] **Deductible**:] [$0 - $9750]
[[Preferred][Generic] Drug: [$0 - $9750]]
[[Non-preferred] Generic Drug: [$0 - $9750]]
[[Preferred] Brand Name Drug: [$0 - $9750]]
[[Non-Preferred] Brand Name Drug: [$0 - $9750]]
[Subject to [Plan] [Integrated] [Family] Deductible and Coinsurance.]

[**Participating Pharmacy**] **Deductible**:] [$0 - $9750]
[[Preferred][Generic] Drug: [$0 - $9750]]
[[Non-preferred] Generic Drug: [$0 - $9750]]
[[Preferred] Brand Name Drug: [$0 - $9750]]
[[Non-Preferred] Brand Name Drug: [$0 - $9750]]
[Subject to [Plan] [Integrated] [Family] Deductible and Coinsurance.]

[**Non-Participating Pharmacy**] **Deductible**:] [$0 - $9750]
[[Preferred][Generic] Drug: [$0 - $9750]]
[[Non-preferred] Generic Drug: [$0 - $9750]]
[[Preferred] Brand Name Drug: [$0 - $9750]]
[[Non-Preferred] Brand Name Drug: [$0 - $9750]]
[Subject to [Plan] [Integrated] [Family] Deductible and Coinsurance.]

[**Mail Service Prescription Drug [Individual] [Integrated] Deductible**:] [$0 - $9750]
[[Preferred][Generic] Drug: [$0 - $9750]]
[[Non-Preferred] Generic Drug: [$0 - $9750]]
[[Preferred] Brand Name Drug: [$0 - $9750]]
[[Non-Preferred] Brand Name Drug: [$0 - $9750]]
[Subject to Plan [Individual] Deductible and Coinsurance.]

[**Mail Service Prescription Drug [Integrated] Family Maximum Deductible**:] [$0 - $9750]
[[Preferred][Generic] Drug: [$0 - $9750]]
[[Non-preferred] Generic Drug: [$0 - $9750]]
[[Preferred] Brand Name Drug: [$0 - $9750]]
[[Non-Preferred] Brand Name Drug: [$0 - $9750]]
[Subject to [Integrated] [Family] Deductible and Coinsurance.]

[Tier 1] [Copayment:]

[**Designated Specialty Pharmacy Provider**:] [$0 - $100]
[[Preferred][Generic] Drug: [$0 - $50
[[Non-preferred] Generic Drug: [$1 - $50]]
[[Preferred] Brand Name Drug: [$1-100]]
[[Non-Preferred] Brand Name Drug: [$1-100]]

[**Participating Pharmacy**:] [$0 - $100]
[[Preferred][Generic] Drug: [$0 - $50]]
[[Non-preferred] Generic Drug: [$1 - $50]]
[[Preferred] Brand Name Drug: [$1-100]]
[[Non-Preferred] Brand Name Drug: [$1-100]]

[**Non-Participating Pharmacy**:] [$0 - $100]
[Reimbursed at the Contracted Rates]
[[Preferred] [Generic] Drug: [$0 - $50]]
[[Non-preferred] Generic Drug: [$1 - $50]]
[[Preferred] Brand Name Drug: [$1-100]]
[[Non-Preferred] Brand Name Drug: [$1-100]]

[**Mail Service Prescription Drug Vendor**:] [$0 - $100]
[[Preferred][Generic] Drug: [$0 - $50]]
[[Non-preferred] Generic Drug: [$1 - $50]]
[[Preferred] Brand Name Drug: [$1-100]]
[[Non-Preferred] Brand Name Drug: [$1-100]]

[Tier 1] Coinsurance:

[**Designated Specialty Pharmacy Provider**:] [0% - 100%]
[[Preferred][Generic] Drug: [0% - 100%]]
[[Non-preferred] Generic Drug: [0% - 100%]]
[[Preferred] Brand Name Drug: [0% - 100%]]
[[Non-Preferred] Brand Name Drug: 0% - 100%]]

[**Participating Pharmacy**:] [0% - 100%]
[[Preferred][Generic] Drug: [0% - 100%]]
[[Non-preferred] Generic Drug: [0% - 100%]]
[[Preferred Brand Name Drug: [0% - 100%]]
[[Non-Preferred Brand Name Drug: 0% - 100%]]

[**Non-Participating Pharmacy**:] [0% - 100%]
[Reimbursed at the Contracted Rates]
[[Preferred][Generic] Drug: [0% - 100%]]
[[Non-preferred] Generic Drug: [0% - 100%]]
[[Preferred] Brand Name Drug: [0% - 100%]]
[[Non-Preferred] Brand Name Drug: 0% - 100%]]

[**Mail Service Prescription Drug Vendor**:] [0% - 100%]
[[Preferred][Generic] Drug: [0% - 100%]]
[[Non-preferred] Generic Drug: [0% - 100%]]
[[Preferred] Brand Name Drug: [0% - 100%]]
[[Non-Preferred] Brand Name Drug: 0% - 100%]]

[Tier 1] Out-of-Pocket Limits	**[Individual]**	**[Common][Integrated][Family]**
[**Designated Specialty Pharmacy Provider**]	[$0-$25,000]	[$0-$25,000]
[[Preferred][Generic] Drug:]	[$0-$25,000]	[$0-$25,000]
[[Non-preferred] Generic Drug:]	[$0-$25,000]	[$0-$25,000]
[[Preferred] Brand Name Drug:]	[$0-$25,000]	[$0-$25,000]
[[Non-Preferred] Brand Name Drug:]	[$0-$25,000]	[$0-$25,000]
[**Participating Pharmacy**]	[$0-$25,000]	[$0-$25,000]
[[Preferred][Generic] Drug:]	[$0-$25,000]	[$0-$25,000]
[[Non-preferred] Generic Drug:]	[$0-$25,000]	[$0-$25,000]
[[Preferred Brand Name Drug:]	[$0-$25,000]	[$0-$25,000]
[[Non-Preferred Brand Name:]	[$0-$25,000]	[$0-$25,000]
[**Non-Participating Pharmacy**]	[$0-$25,000]	[$0-$25,000]
[[Preferred][Generic] Drug:]	[$0-$25,000]	[$0-$25,000]
[[Non-preferred] Generic Drug:]	[$0-$25,000]	[$0-$25,000]
[[Preferred] Brand Name Drug:]	[$0-$25,000]	[$0-$25,000]
[[Non-Preferred] Brand Name Drug:]	[$0-$25,000]	[$0-$25,000]
[**Mail Service Prescription Drug Vendor**]	[$0-$25,000]	[$0-$25,000]
[[Preferred][Generic] Drug:]	[$0-$25,000]	[$0-$25,000]
[[Non-preferred] Generic Drug:]	[$0-$25,000]	[$0-$25,000]
[[Preferred] Brand Name Drug:]	[$0-$25,000]	[$0-$25,000]
[[Non-Preferred] Brand Name Drug:]	[$0-$25,000]	[$0-$25,000]

[Tier 2] [Copayment:]

[**Designated Specialty Pharmacy Provider**:] [$0 - $25]
[[Preferred][Generic] Drug: [$0 - $25]]
[[Non-preferred] Generic Drug: [$1 - $25]]
[[Preferred] Brand Name Drug: [$1-75]]
[[Non-Preferred] Brand Name Drug: [$1-75]]
[Subject to [Plan][Integrated][Family] Deductible and Coinsurance.]

[**Participating Pharmacy**:] [$0 - $25]
[[Preferred][Generic] Drug: [$0 - $25]]
[[Non-preferred] Generic Drug: [$1 - $25]]
[[Preferred] Brand Name Drug: [$1-75]]
[[Non-Preferred] Brand Name Drug: [$1-75]]
[Subject to [Plan][Integrated][Family] Deductible and Coinsurance.]

[**Non-Participating Pharmacy**:] [$0 - $25]
[Reimbursed at the Contracted Rates]
[[Preferred] [Generic] Drug: [$0 - $25]]
[[Non-preferred] Generic Drug: [$1 - $25]]
[[Preferred] Brand Name Drug: [$1-75]]
[[Non-Preferred] Brand Name Drug: [$1-75]]
[Subject to [Plan][Integrated][Family] Deductible and Coinsurance.]

[**Mail Service Prescription Drug Vendor**:] [$0 - $25]
[[Preferred][Generic] Drug: [$0 - $25]]
[[Non-preferred] Generic Drug: [$1 - $25]]
[[Preferred] Brand Name Drug: [$1-75]]
[[Non-Preferred] Brand Name Drug: [$1-75]]
[Subject to [Plan][Integrated][Family] Deductible and Coinsurance.]

[Tier 2] Coinsurance

[**Designated Specialty Pharmacy Provider**:] [0% - 100%]
[[Preferred][Generic] Drug: [0% - 100%]]
[[Non-preferred] Generic Drug: [0% - 100%]]
[[Preferred] Brand Name Drug: [0% - 100%]]
[[Non-Preferred] Brand Name Drug: 0% - 100%]]
[No Prescription Drug Coinsurance. Subject to [Plan] Coinsurance.]

[**Participating Pharmacy**:] [0% - 100%]
[[Preferred][Generic] Drug: [0% - 100%]]
[[Non-preferred] Generic Drug: [0% - 100%]]
[[Preferred Brand Name Drug: [0% - 100%]]
[[Non-Preferred Brand Name Drug: 0% - 100%]]
[No Prescription Drug Coinsurance. Subject to [Plan] Coinsurance.]

[**Non-Participating Pharmacy**:] [0% - 100%]
[Reimbursed at the Contracted Rates]
[[Preferred][Generic] Drug: [0% - 100%]]
[[Non-preferred] Generic Drug: [0% - 100%]]
[[Preferred] Brand Name Drug: [0% - 100%]]
[[Non-Preferred] Brand Name Drug: 0% - 100%]]
[No Prescription Drug Coinsurance. Subject to [Plan] Coinsurance.]

[**Mail Service Prescription Drug Vendor**:] [0% - 100%]
[[Preferred][Generic] Drug: [0% - 100%]]
[[Non-preferred] Generic Drug: [0% - 100%]]
[[Preferred] Brand Name Drug: [0% - 100%]]
[[Non-Preferred] Brand Name Drug: 0% - 100%]]
[No Prescription Drug Coinsurance. Subject to [Plan] Coinsurance.]

[Tier 2] Out-of-Pocket Limits	**[Individual]**	**[Common][Integrated][Family]**
[**Designated Specialty Pharmacy Provider**]	[$0-$25,000]	[$0-$25,000]
[[Preferred][Generic] Drug:]	[$0-$25,000]	[$0-$25,000]
[[Non-preferred] Generic Drug:]	[$0-$25,000]	[$0-$25,000]
[[Preferred] Brand Name Drug:]	[$0-$25,000]	[$0-$25,000]
[[Non-Preferred] Brand Name Drug:]	[$0-$25,000]	[$0-$25,000]
[Subject to [Plan] Out-of-Pocket Limits]		
[**Participating Pharmacy**]	[$0-$25,000]	[$0-$25,000]
[[Preferred][Generic] Drug:]	[$0-$25,000]	[$0-$25,000]
[[Non-preferred] Generic Drug:]	[$0-$25,000]	[$0-$25,000]
[[Preferred Brand Name Drug:]	[$0-$25,000]	[$0-$25,000]
[[Non-Preferred Brand Name:]	[$0-$25,000]	[$0-$25,000]
[Subject to [Plan] Out-of-Pocket Limits]		
[**Non-Participating Pharmacy**]	[$0-$25,000]	[$0-$25,000]
[[Preferred][Generic] Drug:]	[$0-$25,000]	[$0-$25,000]
[[Non-preferred] Generic Drug:]	[$0-$25,000]	[$0-$25,000]
[[Preferred] Brand Name Drug:]	[$0-$25,000]	[$0-$25,000]
[[Non-Preferred] Brand Name Drug:]	[$0-$25,000]	[$0-$25,000]
[Subject to [Plan] Out-of-Pocket Limits]		
[**Mail Service Prescription Drug Vendor**]	[$0-$25,000]	[$0-$25,000]
[[Preferred][Generic] Drug:]	[$0-$25,000]	[$0-$25,000]
[[Non-preferred] Generic Drug:]	[$0-$25,000]	[$0-$25,000]
[[Preferred] Brand Name Drug:]	[$0-$25,000]	[$0-$25,000]
[[Non-Preferred] Brand Name Drug:]	[$0-$25,000]	[$0-$25,000]
[Subject to [Plan] Out-of-Pocket Limits]		

[Tier 3] [Copayment:]

[**Designated Specialty Pharmacy Provider**:] [$0 - $25]
[[Preferred][Generic] Drug: [$0 - $25]]
[[Non-preferred] Generic Drug: [$1 - $25]]
[[Preferred] Brand Name Drug: [$1-75]]
[[Non-Preferred] Brand Name Drug: [$1-75]]
[Subject to [Plan] Deductible and Coinsurance.]

[**Participating Pharmacy**:] [$0 - $25]
[[Preferred][Generic] Drug: [$0 - $25]]
[[Non-preferred] Generic Drug: [$1 - $25]]
[[Preferred] Brand Name Drug: [$1-75]]
[[Non-Preferred] Brand Name Drug: [$1-75]]
[Subject to [Plan] Deductible and Coinsurance.]

[**Non-Participating Pharmacy**:] [$0 - $25]
[Reimbursed at the Contracted Rates]
[[Preferred] [Generic] Drug: [$0 - $25]]
[[Non-preferred] Generic Drug: [$1 - $25]]
[[Preferred] Brand Name Drug: [$1-75]]
[[Non-Preferred] Brand Name Drug: [$1-75]]
[Subject to [Plan] Deductible and Coinsurance.]

[**Mail Service Prescription Drug Vendor**:] [$0 - $25]
[[Preferred][Generic] Drug: [$0 - $25]]
[[Non-preferred] Generic Drug: [$1 - $25]]
[[Preferred] Brand Name Drug: [$1-75]]
[[Non-Preferred] Brand Name Drug: [$1-75]]
[Subject to [Plan] Deductible and Coinsurance.]

[Tier 3] Coinsurance

[**Designated Specialty Pharmacy Provider**:] [0% - 100%]
[[Preferred][Generic] Drug: [0% - 100%]]
[[Non-preferred] Generic Drug: [0% - 100%]]
[[Preferred] Brand Name Drug: [0% - 100%]]
[[Non-Preferred] Brand Name Drug: 0% - 100%]]
[No Prescription Drug Coinsurance. Subject to [Plan] Coinsurance.]

[**Participating Pharmacy**:] [0% - 100%]
[[Preferred][Generic] Drug: [0% - 100%]]
[[Non-preferred] Generic Drug: [0% - 100%]]
[[Preferred Brand Name Drug: [0% - 100%]]
[[Non-Preferred Brand Name Drug: 0% - 100%]]
[No Prescription Drug Coinsurance. Subject to [Plan] Coinsurance.]

[**Non-Participating Pharmacy**:] [0% - 100%]
[Reimbursed at the Contracted Rates]
[[Preferred][Generic] Drug: [0% - 100%]]
[[Non-preferred] Generic Drug: [0% - 100%]]
[[Preferred] Brand Name Drug: [0% - 100%]]
[[Non-Preferred] Brand Name Drug: 0% - 100%]]
[No Prescription Drug Coinsurance. Subject to [Plan] Coinsurance.]

[**Mail Service Prescription Drug Vendor**:] [0% - 100%]
[[Preferred][Generic] Drug: [0% - 100%]]
[[Non-preferred] Generic Drug: [0% - 100%]]
[[Preferred] Brand Name Drug: [0% - 100%]]
[[Non-Preferred] Brand Name Drug: 0% - 100%]]
[No Prescription Drug Coinsurance. Subject to [Plan] Coinsurance.]

[Tier 3] Out-of-Pocket Limits	**[Individual]**	**[Common][Integrated][Family]**
[**Designated Specialty Pharmacy Provider**]	[$0-$25,000]	[$0-$25,000]
[[Preferred][Generic] Drug:]	[$0-$25,000]	[$0-$25,000]
[[Non-preferred] Generic Drug:]	[$0-$25,000]	[$0-$25,000]
[[Preferred] Brand Name Drug:]	[$0-$25,000]	[$0-$25,000]
[[Non-Preferred] Brand Name Drug:]	[$0-$25,000]	[$0-$25,000]
[Subject to [Plan] Out-of-Pocket Limits]		
[**Participating Pharmacy**]	[$0-$25,000]	[$0-$25,000]
[[Preferred][Generic] Drug:]	[$0-$25,000]	[$0-$25,000]
[[Non-preferred] Generic Drug:]	[$0-$25,000]	[$0-$25,000]
[[Preferred Brand Name Drug:]	[$0-$25,000]	[$0-$25,000]
[[Non-Preferred Brand Name]	[$0-$25,000]	[$0-$25,000]
[Subject to [Plan] Out-of-Pocket Limits]		
[**Non-Participating Pharmacy**]	[$0-$25,000]	[$0-$25,000]
[[Preferred][Generic] Drug:]	[$0-$25,000]	[$0-$25,000]
[[Non-preferred] Generic Drug:]	[$0-$25,000]	[$0-$25,000]
[[Preferred] Brand Name Drug:]	[$0-$25,000]	[$0-$25,000]
[[Non-Preferred] Brand Name Drug:]	[$0-$25,000]	[$0-$25,000]
[Subject to [Plan] Out-of-Pocket Limits]		
[**Mail Service Prescription Drug Vendor**]	[$0-$25,000]	[$0-$25,000]
[[Preferred][Generic] Drug:]	[$0-$25,000]	[$0-$25,000]
[[Non-preferred] Generic Drug:]	[$0-$25,000]	[$0-$25,000]
[[Preferred] Brand Name Drug:]	[$0-$25,000]	[$0-$25,000]
[[Non-Preferred] Brand Name Drug:]	[$0-$25,000]	[$0-$25,000]
[Subject to [Plan] Out-of-Pocket Limits]		

[[$0-500] [Calendar Year] [Benefit Period] [Per Cause] [Time Period] [Plan Year] [Brand Name Drug] Deductible. [The Deductible applies to [level] [group][1][A][,] [level] [group] [2] [B] [,] [level] [group [3] [C] [and] [level] [group] [4] [D] [and] [level] [group] [5] [E]] [Brand Name] Drugs.]	
[[Therapeutic l] [Class] [1] [a] drugs] [Deductible] [Drugs appearing on the drug list]	[$0 - $9750]
[[Therapeutic l] [Class] [1] [a] drugs] [Drugs appearing on the drug list]	[Not Covered] [$0-$100] [10-100%] [Copayment] [with a minimum Copayment of [$5-50]] [Amounts exceeding [$5-100]]]allowance] [up to a maximum Copayment of [$0-$1000]] [per Prescription or refill.][for the first XX of Prescriptions][then $XX for the next XX of Prescription] [then $XX for subsequent Prescriptions]]
[[Therapeutic l] [Class] [2] [B] drugs] [Deductible]	[$0 - $9750]
[[Therapeutic l] [Class] [2] [B] drugs]	[Not Covered] [$0-$100] [10-100%] [Copayment] [with a minimum Copayment of [$5-50]] [Amounts exceeding [$5-100]]]allowance] [up to a maximum Copayment of [$0-$1000]] [per Prescription or refill].[for the first XX of Prescriptions][then $XX for the next XX of Prescription] [then $XX for subsequent Prescriptions]]
[[Therapeutic l] [Class] [3] [C] drugs] [Deductible]	[$0 - $9750]
[[Therapeutic l] [Class] [3] [C] drugs]	[Not Covered] [$0-$100] [10-100%] [Copayment] [with a minimum Copayment of [$5-50]] [Amounts exceeding [$5-100]]]allowance] [up to a maximum Copayment of [$0-$1000]] [per Prescription or refill].[for the first XX of Prescriptions][then $XX for the next XX of Prescription] [then $XX for subsequent Prescriptions]]
[[Therapeutic l] [Class] [4] [D] drugs] [Deductible]	[$0 - $9750]
[[Therapeutic l] [Class] [4] [D] drugs]	[Not Covered] [$0-$100] [10-100%] [Copayment] [with a minimum Copayment of [$5-50]] [Amounts exceeding [$5-100]]]allowance] [up to a maximum Copayment of [$0-$1000]] [per Prescription or refill].[for the first XX of Prescriptions][then $XX for the next XX of Prescription] [then $XX for subsequent Prescriptions]]

[[Therapeutic l] [Class] [5] [E] drugs] [Deductible]	[$0 - $9750]
[[Therapeutic l] [Class] [5] [E] drugs]	[Not Covered] [$0-$100] [10-100%] [Copayment] [with a minimum Copayment of [$5-50]] [Amounts exceeding [$5-100]]]allowance] [up to a maximum Copayment of [$0-$1000]] [per Prescription or refill].[for the first XX of Prescriptions][then $XX for the next XX of Prescription] [then $XX for subsequent Prescriptions]]

BEN: 220.001.001.GE

[**Life Insurance**:]

[Certificate Holder	$[0-250,000]]
[Covered Dependent Spouse	$[0-250,000]]
[Covered Dependent Child(ren)	$[0-50,000]]

[This Amount of Life Insurance will be subject to the Age Reduction Percentages listed below:]

[Age Reduction Percentages:]

[Reduction Age:]	[Reduction Percentage:]
[[55]	Reduces to [70]% of the amount in force immediately prior to age [55]]
[[65]	Reduces to [60]% of the amount in force immediately prior to age [65]]
[[70]	Reduces to [60]% of the amount in force immediately prior to age [70]]

BEN: 225.001.GE

[**Accelerated Benefit**:]

[[Up to] [50%] of the Life Insurance Benefit.]

BEN: 230.001.GE

[**Accidental Death & Dismemberment Insurance**[**for Employee**]:]

[The Accidental Death Benefit will be] [[an amount equal to] [and in addition to]] the amount of Life Insurance [(including any applicable adjustment or reduction)] in effect on the date of loss.]

[Certificate Holder	$[10,000] [2X's] [3X's]]
[Dependent Covered Spouse	$[5,000] [2X's] [3X's]]
[Dependent Covered Child(ren)	$[2,000] [2X's] [3X's]]

BEN: 235.001.GE

Time Insurance Company
[501 West Michigan
Milwaukee, WI 53203]

MEDICAL EXPENSE COVERAGE
OUTLINE OF COVERAGE

This outline of coverage provides a brief description of the important features of Your certificate. This is not the insurance contract. The certificate itself sets forth in detail the limits and conditions of coverage as well as the rights and obligations of both You and the insurance company. It is important that You READ YOUR CERTIFICATE CAREFULLY.

MAJOR MEDICAL EXPENSE COVERAGE: The certificate is designed to provide coverage for major hospital, medical, and surgical expenses Incurred as a result of a covered Sickness or Injury.

[AUTHORIZATION REQUIREMENT: To be eligible to receive the maximum benefits available, read the Utilization Review Provisions section in the certificate carefully. Failure to follow the Utilization Review Provisions section could result in no payment or a reduction in benefits.]

PAYMENT OF BENEFITS: After the Covered Person has paid any [Access Fee,] [Copayment,] [Deductible,] [Coinsurance] and any other applicable fees, We will pay benefits for Covered Charges. Benefits are subject to the Maximum Lifetime Benefit and any other maximum benefit provided under the plan.

<table>
<tr><td colspan="2">[COVERAGE INFORMATION</td></tr>
<tr><td>[Medical Benefit Coverage:

[Access Fee: $_____]
[Copayment: $_____]
[Deductible: $_____]
[Coinsurance: $_____]]</td><td>[Outpatient Prescription Drug Benefit Coverage:

[Generic Drug Copayment: $_____]
[Brand Name Drug Copayment: $_____]
[Prescription Drug Deductible: $_____]
[Prescription Drug Coinsurance: $_____]]</td></tr>
<tr><td colspan="2">[Maximum Lifetime Benefit for All Services: $_____]</td></tr>
<tr><td colspan="2">PREMIUM INFORMATION</td></tr>
<tr><td colspan="2">Premium Payment Mode: _____ TOTAL MODAL PREMIUM AMOUNT: $_____]</td></tr>
</table>

[COVERED CHARGE: An expense that We determine meets all of the following requirements:

- [It is Incurred for treatment, services or supplies provided by a Health Care Practitioner, facility or supplier.]
- [It is Incurred by a Covered Person while coverage is in force under the plan as the result of a Sickness [that first manifests itself on or after the Covered Person's Effective Date] or an Injury [or for preventive medicine services] [or family planning services].]
- [It is Incurred for services or supplies listed in the Medical Benefits section [or Outpatient Prescription Drug Benefits section][, unless the charges are Incurred during a Benefit Waiting Period].]
- [It is Incurred for treatment, services or supplies which are Medically Necessary.]
- [It is not in excess of the Maximum Allowable Amount.]

Charges from the Covered Person's [Non-Network] [Non-Participating] Provider may exceed the Maximum Allowable Amount. The Covered Person is responsible for any amounts in excess of the Maximum Allowable Amount, as determined by Us.]

[MAXIMUM ALLOWABLE AMOUNT: The maximum amount of a billed charge We will consider when determining Covered Charges, as determined by Us. Benefit payments of Covered Charges are not based on the amount billed but, rather, they are based on what We determine to be the Maximum Allowable Amount. Amounts billed in excess of the Maximum Allowable Amount by or on behalf of a Health Care Practitioner, facility or supplier are not payable by Us under the plan.]

OTHER INSURANCE: If there is other insurance which provides coverage for medical expenses, benefits under the certificate will be reduced.

BENEFITS PROVIDED BY THE CERTIFICATE: Only the services and supplies listed in the certificate will be considered Covered Charges. How Covered Charges are paid and the maximum benefit for the covered services and supplies are shown in the Benefit Summary. The certificate provides benefits for the following Covered Charges:

- [Inpatient Medical Facility Services: Daily room and board, routine nursing services and other Medically Necessary services received in an Acute Medical Facility.]
- [Outpatient Medical Facility Services: Services received in an Acute Medical Facility's Outpatient department, a Free-Standing Facility or an Urgent Care Facility.]
- [[Doctor] [Physician] Office Visit: Evaluation and management services as defined in the most recent edition of Current Procedural Terminology [and preventive medicine services] that are received during an Office Visit.]
- [Preventive Medicine Services: Well child care, adult care and diagnostic services as recommended by the United States Preventative Services Task Force [after satisfaction of a Benefit Waiting Period].]
- Colorectal Cancer Examination Services
- Loss or Impairment of Speech or Hearing Services
- Medical Food Services
- [Diagnostic Imaging Services and Laboratory Services [: Coverage is provided after satisfaction of a Benefit Waiting Period].]
- [Outpatient Physical Medicine Services: [Physical Therapy, Occupational Therapy, Speech Therapy,] [pulmonary rehabilitation programs,] [adjustments,] [manipulations,] [massage therapy,] [Cardiac Rehabilitation Programs] [and] [services for treatment of Developmental Delay].]
- [Outpatient Alternative Medicine Services: [Acupuncture,] [massage therapy,] [nutritional counseling,] [meditation or relaxation therapy,] [and] [naturopathic medicine] [after satisfaction of a Benefit Waiting Period].]
- [Durable Medical Equipment and Personal Medical Equipment: Rental or purchase of such items as a wheelchair, basic hospital bed, crutches, an initial permanent basic artificial limb or eye, external breast prostheses, oxygen, orthopedic braces and other equipment and supplies that are approved in advance by Us.]

- [Complications of Pregnancy: Coverage for a Sickness associated with a pregnancy. However, hyperemesis gravidarum and a non-emergency caesarean section delivery would not be covered.]

- [Health Care Practitioner Services: Surgical services, anesthesia and other services performed by a Health Care Practitioner.]

- [Professional Ground [or Air] Ambulance Services: Transportation in an ambulance to the nearest Acute Medical Facility that can treat the Sickness or Injury.]

- [Home Health Care Services: [Visits by a nurse,] [respiratory therapy] [and] [injectable drug therapy] received in the home and provided by a Home Health Care Agency.]

- [Hospice Services: Inpatient services when confined in a Hospice facility and home care services when care is provided by a licensed Hospice for a person who is terminally ill.]

- [Inpatient Rehabilitation Services: Services received as an Inpatient in an Acute Medical Rehabilitation Facility.]

- [Subacute Rehabilitation Facility and Skilled Nursing Facility Care: Services received in a Subacute Rehabilitation Facility or Skilled Nursing Facility when the confinement is in lieu of acute hospitalization or when admitted within [14 days] after discharge from an Acute Medical Facility after a confinement of at least [3 days].]

- [Family Planning Services: Office Visits for contraception management, including the dispensing of FDA-approved contraceptive drugs or devices.]

- [Sterilization: Services for permanent sterilization [after satisfaction of a Benefit Waiting Period].]

- [Temporomandibular Joint (TMJ) or Craniomandibular Joint (CMJ) Dysfunction: Surgical treatment for services that are included in a treatment plan authorized by Us prior to the surgery. Non-surgical treatment is limited to [diagnostic examinations,] [Diagnostic Imaging services,] [injection of muscle relaxants,] [therapeutic drug injections,] [Physical Therapy,] [diathermy therapy] [and] [ultrasound therapy].]

- [Diabetic Services: Routine eye exams, nutritional counseling, diabetic training, routine foot care, home glucose monitoring, [diabetic supplies] [and] [insulin, syringes, needles, lancets and testing agents].]

- [Growth Hormone Therapy Services: Services that are clinically proven to be effective for growth hormone deficiency, growth retardation secondary to chronic renal failure before or during dialysis or AIDS wasting syndrome.]

- [Tonsils and Adenoids: Services for removal of tonsils and adenoids [after satisfaction of a Benefit Waiting Period].]

- [[Bunions,] [Hemorrhoids] [Inguinal Hernia] [and] [Varicose Veins]: Services for surgical treatment of [bunions,] [hemorrhoids] [inguinal hernia] [and] [varicose veins] [after satisfaction of a Benefit Waiting Period].]

- [Blood Product Transfusions: Whole blood, blood plasma and blood products if not replaced.]

- [Transplants: Kidney, cornea, skin, lung, heart, liver, simultaneous heart/lung, simultaneous kidney/pancreas and allogeneic and autologous bone marrow transplant/stem cell rescue when a transplant is authorized in advance by Us prior to transplant evaluation, testing, preparative treatment or donor search. [The maximum transplant benefit applies to all Covered Charges for transplants, combined transplants, and sequential transplants, including replacement or subsequent transplants of the same organ.]]

- [Behavioral Health: Inpatient services when confined in an Acute Behavioral Health Inpatient Facility or a Behavioral Health Rehabilitation and Residential Facility. Outpatient services when care is received in an Intensive Outpatient Behavioral Health Program, a Partial Hospital and Day Treatment Behavioral Health Facility or Program or by a Health Care Practitioner who is licensed to treat Behavioral Health in an office setting.]

- [Substance Abuse: Inpatient services when confined in an Acute Behavioral Health Inpatient Facility or a Behavioral Health Rehabilitation and Residential Facility. Outpatient services when care is received in an Intensive Outpatient Behavioral Health Program, a Partial Hospital and Day Treatment Behavioral Health Facility or Program or by a Health Care Practitioner who is licensed to treat Substance Abuse in an office setting.]

- [Reconstructive Surgery: To restore function after an Injury; that is incidental to or follows a covered surgery resulting from a Sickness or an Injury of the involved part; that follows a Medically Necessary mastectomy; or because of congenital Sickness or anomaly of a Covered Dependent child that resulted in a functional defect.]

- [Dental Services: Teeth extractions required prior to radiation therapy or treatment of a Dental Injury.]

- [Intravenous Injectable Parenteral Drug Therapy [and Specialty Pharmaceuticals]: Services for total parenteral nutrition and other fluids, blood and blood products, and medications that would be administered intravenously.]

- [Non-Intravenous Injectable Parenteral Drug Therapy [and Specialty Pharmaceuticals]: Services for Prescription Drugs that can be administered by means of intramuscular or subcutaneous injection.]

- [Telehealth Services: Services for medical consultation between a Health Care Practitioner and a Covered Person through the use of modern telecommunication and information technology.]

- [Telemedicine Services: Services for medical consultation between Health Care Practitioners regarding a Covered Person through the use of advanced telecommunications technology.]

- [World Wide Coverage: Services received outside of the United States if such treatment would be covered when received in the United States.]

- [Alternate Medical Care Plan: A special arrangement that is made with You, a Health Care Practitioner and Us to provide services to the Covered Person which may exceed a maximum limit for a specific benefit in exchange for the exhaustion of a specified amount of another benefit that is covered under the plan.]

- [Outpatient Prescription Drug Benefits: Benefits are payable for up to a [30 consecutive day] supply for each Prescription Order [or up to a [90 consecutive day] supply for Prescription Drugs that can be obtained through mail order]. [This includes insulin or insulin derivatives when

obtained by prescription, disposable insulin syringes and needles and disposable blood/urine/glucose/acetone testing agents or lancets.] Prescription Drugs that are payable under the Outpatient Prescription Drug Benefits section of the plan are not also payable and do not apply toward satisfying any Out-of-Pocket Limits under any other section of the plan. However, benefits apply toward the Maximum Lifetime Benefit and are also subject to any other maximum benefit provided under the plan.]

[The following benefits are optional and are available for an additional premium:]

- [Maternity Care Services: Prenatal care, delivery, postpartum care [and] [routine well newborn care]. [Coverage is provided after satisfaction of a Benefit Waiting Period.]]

- [Infertility Services: Services for the diagnosis and treatment of infertility [after satisfaction of a Benefit Waiting Period].]

- [Accident Medical Expense: When Covered Charges are received as the result of an Injury, certain Out-of-Pocket Limits may be reduced or waived provided that the services are provided within a specified time period after the date the Injury occurred.]

- [Out-of-Network Travel Benefit: Health Care Practitioner Office Visits, Diagnostic Imaging services, laboratory services and other Urgent Care services received in the United States but out of the Covered Person's Service Area may be payable at a [Network] [Participating] Provider level.]

- [Choice of Network Service Area Benefit: Each Covered Person under the plan may choose a different Service Area so that services may be payable at a [Network] [Participating] Provider level.]

- [Nationwide Network Benefit: We have a network of providers throughout the United States who provide services at discounted rates. Services may be payable under this benefit at a lower Out-of-Pocket Limit than if a [Non-Network] [Non-Participating] Provider would have been selected.]

- [International Coverage: [Health Care Practitioner visits,] [preventive medicine services,] [Diagnostic Imaging services,] [laboratory services,] [drugs prescribed during a Health Care Practitioner visit] [and] [Emergency Treatment] while the Covered Person resides or works outside the United States.]

- [Travel Benefit: If a Covered Person receives Covered Charges while traveling outside of the United States, services may be payable [at the [Network] [Participating] Provider level] provided that the services are not Incurred in a country where there are travel warnings issued by the U.S. State Department.]

- [Life Insurance Benefits: [term life insurance,] [accelerated benefits,] [and] [accidental death benefits].]

PRE-EXISTING CONDITIONS LIMITATION: We will not pay benefits under the plan for an otherwise Covered Charge that is related to a Pre-Existing Condition until the Covered Person has been continuously covered under the plan for [12 months]. A condition that has been specifically excluded from coverage will continue to be excluded after [12 months] of continuous coverage.

[BENEFIT WAITING PERIOD: The period of consecutive days [or months] that must pass after the Effective Date of coverage before a Covered Person is eligible to be covered for [a Sickness,] [other

specific benefits] [and] [or] [preventive medicine services] under the terms of the plan. Each Covered Person is responsible for payment of all services that are received during the Benefit Waiting Period. [A Sickness that occurs within the first [15 days] after the Covered Person's Effective Date of coverage will not be covered for a period of [12 months] after the Effective Date.]]

EXCLUSIONS: We will not pay benefits for any of the following:

- [Charges for work-related Sickness or Injury eligible for benefits under worker's compensation, employers' liability or similar laws even when the Covered Person does not file a claim for benefits. Sickness or Injury that arises out of, or is the result of, any work for wage or profit.]

- [Charges for treatment or services Incurred due to Sickness or Injury of which a contributing cause was the Covered Person's voluntary attempt to commit, participation in or commission of a felony, whether or not charged[, or as a consequence of the Covered Person being under the influence of any illegal or non-prescribed controlled substance while committing a felony.]

- [Charges for Sickness or Injury caused or aggravated by suicide, attempted suicide or self-inflicted Sickness or Injury[, even if the Covered Person did not intend to cause the harm which resulted from the action which led to the self-inflicted Sickness or Injury.]

- [Charges caused by or contributed to by a war or any act of war, whether declared or undeclared; participation in the military service of any country or international organization[, including non-military units supporting such forces]; foreign [or domestic] acts of terrorism that result in a nationwide epidemic].]

- [Charges that are payable or reimbursable by Medicare Part A, Part B or Part D, where permitted by law.] [If a Covered Person at any time was eligible to enroll in the Medicare program (including Part B and Part D) but did not do so, the benefits under the plan will be reduced by any amount that would have been reimbursed by Medicare.]

- [Charges that are: payable or reimbursable by any other government law or program, except Medicaid (Medi-Cal in California); for free treatment provided in a federal, veteran's, state or municipal medical facility; for services that a Covered Person has no legal obligation to pay or for which no charge would be made if the Covered Person did not have a health plan or insurance coverage.]

- [Charges for: [vision care that is routine[, except as otherwise covered in the Diabetic Services provision in the Medical Benefits section];] [glasses;] [contact lenses, except when used to aid in healing an eye or eyes due to a Sickness or an Injury;] [vision therapy, exercise or training;] [surgery including any complications arising therefrom to correct visual acuity including, but not limited to, lasik and other laser surgery, radial keratotomy services or surgery to correct astigmatism, nearsightedness (myopia) and/or farsightedness (presbyopia)].]

- [Charges for foot conditions including, but not limited to, expenses for: [flat foot conditions;] [foot supportive devices, including orthotics and corrective shoes;] [foot subluxation treatment;] [care of corns;] [bunions, except capsular or bone surgery;] [calluses;] [toenails, except for ingrown toenails;] [fallen arches;] [weak feet;] [chronic foot strain;] [or] [symptomatic complaints of the feet;] [hygienic foot care that is routine[, except as otherwise covered in the Diabetic Services provision in the Medical Benefits section]].]

- [Charges for: [hearing care that is routine;] [any artificial hearing device, cochlear implant, auditory prostheses or other electrical, digital, mechanical or surgical means of enhancing, creating or restoring auditory comprehension].]

- [Charges for chemical peels, reconstructive or plastic surgery that does not alleviate a functional impairment and other charges that are primarily a Cosmetic Service, except as otherwise covered in the Reconstructive Surgery provision in the Medical Benefits section.]

- [Charges that: [are not specifically listed as a Covered Charge in the Medical Benefits section [or Outpatient Prescription Drug Benefits section;] [are complications of a non-covered service;] [are Incurred before the Covered Person's Effective Date or after the termination date of coverage[, except as provided under any Extension of Benefits provision];] [are complications of any Sickness or Injury that existed prior to the Effective Date;] [are not documented in the Health Care Practitioner's or Medical Supply Provider's records;] [are related to the supervision of laboratory services that do not involve written consultation by a Health Care Practitioner including, but not limited to, laboratory interpretation;] [are complications resulting from leaving a licensed medical facility against the advice of the Covered Person's Health Care Practitioner].]

- [Charges for services ordered, directed or performed by a Health Care Practitioner or supplies purchased from a Medical Supply Provider who is [a Covered Person,] an Immediate Family Member, [employer of a Covered Person] or a person who ordinarily resides with a Covered Person.] [Services provided by the Covered Person's Immediate Family Member, an employer, or anyone residing with the Covered Person.]

- [Charges for: [a private duty nurse;] [a private duty professional skilled nursing service;] [a masseur, masseuse or massage therapist;] [a rolfer;] [a home health aide or personnel with similar training and experience;] [a stand-by Health Care Practitioner;] [Home Health Care;] [treatment or services provided by a chiropractor;] [Custodial Care;] [respite care;] [rest care;] [supportive care;] [homemaker services;] [a Health Care Practitioner who is not properly licensed or authorized in the state where services are rendered;] [[phone consultations;] [internet consultations;] [e-mail consultations;] [Telemedicine Services;] [Telehealth Services;] [Health Care Practitioner administrative expenses including, but not limited to, expenses for claim filing, contacting utilization review organizations or case management fees;] [missed appointments;] [sales tax;] [gross receipt tax;] [living expenses; travel; transportation[, except as otherwise covered in the [Professional Ground [or Air] Ambulance Services provision,] [Medical Evacuation Services provision,] [Repatriation Services provision] [or] [Transplants provision] in the Medical Benefits section];] [treatment or services that are furnished primarily for the personal comfort or convenience of the Covered Person, Covered Person's family, a Health Care Practitioner or provider.]]

- [Charges for growth hormone therapy[, including growth hormone medication and its derivatives or other drugs used to stimulate, promote or delay growth or to delay puberty to allow for increased growth][, except as otherwise covered in the Growth Hormone Therapy Services provision in the Medical Benefits section].]

- [Charges for: [dental care that is routine;] [dental charges;] [bridges, crowns, caps, dentures, dental implants or other dental prostheses;] [dental braces or dental appliances;] [extraction of teeth;] [orthodontic charges;] [odontogenic cysts;] [any other expenses for treatment or complications of the teeth and gum tissue[, except as otherwise covered in the Dental Services provision in the Medical Benefits section].]

- [Charges for any appliance, medical or surgical expenses for: [malocclusion or protrusion or recession of the mandible;] [maxillary or mandibular hyperplasia;] [maxillary or mandibular hypoplasia].]

- [Charges for: [behavior modification or behavioral (conduct) problems;] [learning disabilities;] [developmental delays;] [attention deficit disorders;] [educational testing, training or materials;] [cognitive enhancement or training;] [vocational or work hardening programs;] [transitional living].]

- [Charges for: [genetic testing or counseling, genetic services and related procedures for screening purposes [including, but not limited to, amniocentesis and chorionic villi testing;] [infertility diagnosis and treatment for males or females including, but not limited to, drugs and medications regardless of intended use, artificial insemination, in vitro fertilization, reversal of reproductive sterilization and related tests, services or procedures and any treatment to promote conception;] [sterilization;] [family planning;] [cryopreservation of sperm or eggs;] [surrogate pregnancy;] [fetal surgery, treatment or services;] [umbilical cord stem cell or other blood component harvest and storage in the absence of a Sickness or an Injury;] [circumcision].]

- [Charges related to [maternity or pregnancy,] [or] [routine well newborn care including nursery charges at birth,] [or] [non-spontaneous abortion][, except as otherwise covered in the Maternity Care Services provision] [or] [Complications of Pregnancy provision in the Medical Benefits section] [or a maternity rider to the plan].]

- [Charges related to the following conditions, regardless of underlying causes: [sex transformation;] [gender dysphoric disorder;] [gender reassignment;] [treatment of sexual function, dysfunction or inadequacy;] [treatment to enhance, restore or improve sexual energy, performance or desire].]

- [Charges for any over-the-counter or prescription products, drugs or medications in the following categories, whether or not prescribed by a Health Care Practitioner: herbal or homeopathic medicines or products; minerals; health and beauty aids; batteries; appetite suppressants; dietary or nutritional substances or dietary supplements; nutraceuticals; [tube feeding formulas and infant formulas;] [medical foods].]

- [Charges for [non-medical items, self-care or self-help programs;] [aroma therapy;] [meditation or relaxation therapy;] [naturopathic medicine;] [treatment of hyperhidrosis (excessive sweating);] [acupuncture; biofeedback; [neurotherapy;] electrical stimulation; or aversion therapy;] [Inpatient treatment of chronic pain disorders;] [family or marriage counseling;] [applied behavior therapy treatment for autistic spectrum disorders;] [smoking cessation;] [snoring ;] [treatment or prevention of hair loss;] [change in skin pigmentation;] [stress management].]

- [Charges for: [any diagnosis, supplies, treatment or regimen, whether medical or surgical, for purposes of controlling the Covered Person's weight or related to obesity [or morbid obesity], whether or not weight reduction is Medically Necessary or appropriate or regardless of potential benefits for co-morbid conditions;] [weight reduction] [or] [weight control surgery, treatment or programs;] [any type of gastric bypass surgery;] [suction lipectomy;] [physical fitness programs,] [exercise equipment] [or] [exercise therapy][, including health club membership fees or services;] [nutritional counseling][, except as otherwise covered in the Diabetic Services provision in the Medical Benefits section].]

- [Charges for treatment of [Behavioral Health] [or] [Substance Abuse][, whether organic or non-organic, chemical or non-chemical, biological or non-biological in origin and irrespective of cause, basis or inducement][, except as otherwise covered in the [Behavioral Health provision] [or]

[Substance Abuse provision] [Behavioral Health and Substance Abuse provision] in the Medical Benefits section].]

[In addition to the Exclusions listed above, the following additional exclusions apply only to the Outpatient Prescription Drug Benefits section. We will not pay benefits for any of the following:

- [Duplicate prescriptions; replacement of lost, stolen, destroyed, spilled or damaged prescriptions; prescriptions refilled more frequently than the prescribed dosage indicates.]

- [Charges for drugs that are not considered Generic Drugs including, but not limited to, [Brand Name Drugs,] [Compounded Medication] [or] [Specialty Pharmaceuticals].]

- [Contraceptive drugs or devices, oral contraceptives, except as [otherwise covered in the Family Planning Services provision in the Medical Benefits section] [or as] [required by law].]

- [Vaccines and other immunizing agents; biological sera; blood or blood products.]

- [Drugs used to treat, impact or influence quality of life or lifestyle concerns including, but not limited to: [smoking deterrence or cessation;] [athletic performance;] [body conditioning, strengthening, or energy;] [prevention or treatment of hair loss;] [prevention or treatment of excessive hair growth or abnormal hair patterns].]

- [Drugs used to treat, impact or influence: [obesity;] [morbid obesity;] [weight management;] [sex transformation;] [gender dysphoric disorder;] [gender reassignment;] [sexual function, dysfunction or inadequacy;] [sexual energy, performance or desire;] [skin coloring or pigmentation;] [social phobias;] [slowing the normal processes of aging;] [memory improvement or cognitive enhancement;] [daytime drowsiness;] [overactive bladder;] [dry mouth;] [excessive salivation;] [or] [hyperhidrosis (excessive sweating)].]

- [Drugs used for cosmetic purposes as determined by Us;] [drugs used to treat onychomycosis (nail fungus);] [botulinum toxin and its derivatives].]

- [Drugs prescribed for dental services, or unit-dose drugs;] [drugs used in the treatment of chronic fatigue or related syndromes or conditions;] [drugs containing nicotine or its derivatives].]

- [Charges for DDAVP (desmopressin acetate) or other drugs used in the treatment of nocturnal enuresis (bedwetting) for a Covered Person under the age of [8].]

- [Charges for Retin-A (tretinoin) and other drugs used in the treatment or prevention of acne, rosacea or related conditions for a Covered Person age [30 or older].]

- [Drugs or supplies requiring injectable parenteral administration or use, except insulin or Imitrex, unless authorized by Us before they are dispensed.] [Charges for any injectable Prescription Drugs [or Specialty Pharmaceuticals], unless authorized by Us before they are dispensed.] [Any administrative charge for drug injections or administrative charges for any other drugs.]

- [Charges for prescriptions, dosages or dosage forms used for the convenience of the Covered Person or the Covered Person's Immediate Family Member or Health Care Practitioner.]

- [Charges for over-the-counter (OTC) medications that can be obtained without a Health Care Practitioner's Prescription Order, except for injectable insulin;] [or] [drugs that have an over-the-

counter equivalent or contain the same or therapeutically equivalent active ingredient(s) as over-the-counter medication, as determined by Us[, unless specifically authorized for coverage] [by Us] [on Our Drug List].]]

[RENEWABILITY PROVISION: The certificate will remain in force except for any one of the following reasons:

- [Nonpayment of premium.]
- [Fraud or material misrepresentation made by or with the knowledge of any Covered Person applying for the coverage or filing a claim for benefits.]
- [All certificates with the same form number are non-renewed in the state in which Your certificate was issued or the state in which You presently reside.]
- [We terminate or nonrenew health insurance coverage in the individual market in the state in which the certificate was issued or the state in which You presently reside.]
- [The Covered Person moves to a state where We do not provide individual medical insurance coverage.]
- [The Covered Person moves outside of the Service Area if he or she has a PPO plan.]
- [The Covered Person becomes eligible for Medicare, if allowed by federal law.]
- [The Covered Person would no longer be considered a Covered Dependent.]]

PREMIUM: The first page shows the total premium for the coverage that was selected.

_____ _____

Licensed Agent's Signature Date

SERFF Tracking Number:	*ASWX-125719472*	*State:*	*Arkansas*
Filing Company:	*Time Insurance Company*	*State Tracking Number:*	*39500*
Company Tracking Number:	*IHAR00246FIF02*		
TOI:	*H16I Individual Health - Major Medical*	*Sub-TOI:*	*H16I.005C Individual - Other*
Product Name:	*Time Insurance-Base Chassis*		
Project Name/Number:	*Time Insurance-Base Chassis/IH AR00246FIF02*		

Rate Information

Rate data does NOT apply to filing.

SERFF Tracking Number:	*ASWX-125719472*	*State:*	*Arkansas*
Filing Company:	*Time Insurance Company*	*State Tracking Number:*	*39500*
Company Tracking Number:	*IHAR00246FIF02*		
TOI:	*H16I Individual Health - Major Medical*	*Sub-TOI:*	*H16I.005C Individual - Other*
Product Name:	*Time Insurance-Base Chassis*		
Project Name/Number:	*Time Insurance-Base Chassis/IH AR00246FIF02*		

Supporting Document Schedules

Satisfied -Name: Certification/Notice
Review Status: Approved-Closed 07/07/2008
Comments:
Attachment:
AR - READABILITY CERTIFICATION.PDF

Satisfied -Name: Application
Review Status: Approved-Closed 07/07/2008
Comments:
Form number 29400 and 29500 approved 11/1/06

Bypassed -Name: Health - Actuarial Justification
Review Status: Approved-Closed 07/07/2008
Bypass Reason: n/a
Comments:

Satisfied -Name: Outline of Coverage
Review Status: Approved-Closed 07/07/2008
Comments:
See Forms Schedule

Satisfied -Name: Cover Letter
Review Status: Approved-Closed 07/07/2008
Comments:
Attachment:
Cover Letter.PDF

Satisfied -Name: Forms List
Review Status: Approved-Closed 07/07/2008
Comments:
Attachment:
Forms List.PDF

SERFF Tracking Number:	*ASWX-125719472*	*State:*	*Arkansas*
Filing Company:	*Time Insurance Company*	*State Tracking Number:*	*39500*
Company Tracking Number:	*IHAR00246FIF02*		
TOI:	*H16I Individual Health - Major Medical*	*Sub-TOI:*	*H16I.005C Individual - Other*
Product Name:	*Time Insurance-Base Chassis*		
Project Name/Number:	*Time Insurance-Base Chassis/IH AR00246FIF02*		

Satisfied -Name: Marked Benefit Summary

Review Status: Approved-Closed 07/07/2008

Comments:

Attachment:

Marked Benefit Summary.PDF

Satisfied -Name: Marked Amendment 6044

Review Status: Approved-Closed 07/07/2008

Comments:

Attachment:

Marked Amendment 6044.PDF

STATE OF ARKANSAS

READABILITY CERTIFICATION

COMPANY NAME: Time Insurance Company

This is to certify that the form(s) referenced below has achieved a Flesch Reading Ease Score as indicated below and complies with the requirements of Ark. Stat. Ann. Section 66-3251 through 66-3258, cited as the Life and Disability Insurance Policy Language Simplification Act.

Form Number	Score
TIM.6044.AR	50.2
CSD.001.XX	46.6
SER.001.XX	48.9
TIM.BNC.AR	52.5

Signed: _____

Name: Julia Hix-Royer

Title: Vice President

Date: _____

501 West Michigan
P.O. Box 3050
Milwaukee, WI 53201-3050
T 800.800.1212

www.assurant.com

July 1, 2008

Arkansas Department of Insurance
1200 W. Third Street
Little Rock, AR 72201

RE: REVISIONS TO PREVIOUSLY APPROVED FORMS
TIME INSURANCE COMPANY (NAIC #69477; FEIN 39-0658730)
Certificate Amendment Rider (05/2008 Edition): TIM.6044.AR
Benefit Summary (05/2008 Edition): TIM.BNC.AR
Condition Specific Deductible Endorsement CSD.001.XX
Special Exception Rider SER.001.XX
Company Reference No.: IHAR00246FIF02
JOHN ALDEN LIFE INSURANCE COMPANY (NAIC #65080; FEIN 41-0999752)
Certificate Amendment Rider (05/2008 Edition): JIM.6044.AR
Benefit Summary (05/2008 Edition): JIM.BNC.AR
Condition Specific Deductible Endorsement CSD.001.XX
Special Exception Rider SER.001.XX
Company Reference No.: IHAR00237JAF02

Dear Sir or Madam:

The above-referenced revisions to our Benefit Summary form are hereby submitted for your review and approval.

Benefit Summary form JIM.BNC.AR, revised 05/2008, replace form JIM.BNC.AR in its entirety. Benefit Summary form JIM.BNC.AR was previously approved by the Department on October 26, 2005.

For your ease in review, the differences between this updated/revised form and the form previously approved on October 26, 2005 are demarcated in the attached supplementary "marked/redlined" documents.

Upon approval, the amended form will be used to market major medical insurance to individually underwritten members of an association group located in the state of Illinois. Coverage will be offered by independent agents licensed in your state. The association (Master Policyholder) is located in the state of Illinois, and as such, the enclosed amendments have been submitted to the Illinois Insurance Division for their review and approval.

We are also enclosing condition specific deductible endorsement and special exception rider for your review and approval. These forms are being filed for general use in accordance with our

underwriting guidelines for individual market products. Approved rates have already taken into consideration these underwriting principals. In consequence, these forms will not be accompanied by a rate filing.

All forms are subject to minor modifications in paper size, stock, layout, format, company logo and printing specifications of the document upon issue. As mentioned above, some of the provisions/sections are bracketed to provide flexibility as well as to afford future flexibility to adjust to changing regulatory and market needs. Please see the enclosed Statement of Variability for additional information on form adaptability.

Upon approval, the amended form will be used to market major medical insurance to individuals who are members of a non-employer sponsored association, and coverage will be offered by independent agents licensed in your state.

Please note that Wisconsin is the state domicile for both Time Insurance Company and John Alden Life Insurance Company. The state of Wisconsin does not require the filing of forms that are being marketed for out-of-state use with their office.

Assurant Health is comprised of Time Insurance Company and John Alden Life Insurance Company. We are submitting identical forms for each company. The only differences are to the form numbers and company names. Because the forms are identical, we respectfully request that the same analyst review both filings.

Thank you in advance for your time and attention to this filing. Should you have any questions, or require additional information, please contact me at any of the numbers listed below.

Best Regards,

Christine R. Fleming
Senior Contract Compliance Analyst
Legal Department
christine.fleming@assurant.com
Phone: (414) 299-1306
Fax: (414) 299-6168

INDIVIDUAL MEDICAL INSURANCE
FORMS LIST

FORM NUMBER FOR APPROVAL	FORM TITLE AND/OR DESCRIPTION
TIM.CER.AR	Certificate of Medical Insurance (05/2008 Edition)
TIM.6044.AR	Certificate Amendment Rider (05/2008 Edition)
TIM.BNC.AR	Benefit Summary (05/2008 Edition)
The following provisions/sections comprise the entire matrix benefit summary form TIM.BNC.AR. Please note the provision/section numbers will not appear in the final, printed version of the form, but are included in the filing for informational use and reference only.	
BEN: 005.001.001.GE	Matrix Benefit Summary
BEN: 010.001.001.GE	Matrix Benefit Summary
BEN: 010.002.GE	Matrix Benefit Summary
BEN: 015.001.001.GE	Matrix Benefit Summary
BEN: 020.001.GE	Matrix Benefit Summary
BEN: 025.001.GE	Matrix Benefit Summary
BEN: 030.001.001.GE	Matrix Benefit Summary
BEN: 032.001.GE	Matrix Benefit Summary
BEN: 035.001.001.GE	Matrix Benefit Summary
BEN: 036.001.001.AR	Matrix Benefit Summary
BEN: 037.001.001.AR	Matrix Benefit Summary
BEN: 038.001.001.AR	Matrix Benefit Summary
BEN: 040.001.001.GE	Matrix Benefit Summary
BEN: 045.001.001.GE	Matrix Benefit Summary
BEN: 050.001.001.GE	Matrix Benefit Summary
BEN: 055.001.001.GE	Matrix Benefit Summary
BEN: 060.001.001.GE	Matrix Benefit Summary
BEN: 065.001.001.GE	Matrix Benefit Summary
BEN: 070.001.GE	Matrix Benefit Summary
BEN: 075.001.001.GE	Matrix Benefit Summary
BEN: 080.001.GE	Matrix Benefit Summary
BEN: 085.001.GE	Matrix Benefit Summary
BEN: 090.001.001.GE	Matrix Benefit Summary
BEN: 095.001.001.GE	Matrix Benefit Summary
BEN: 100.001.GE	Matrix Benefit Summary
BEN: 105.001.GE	Matrix Benefit Summary
BEN: 110.001.001.GE	Matrix Benefit Summary
BEN: 115.001.001.GE	Matrix Benefit Summary
BEN: 120.001.001.GE	Matrix Benefit Summary
BEN: 125.001.001.GE	Matrix Benefit Summary
BEN: 130.001.001.GE	Matrix Benefit Summary
BEN: 135.001.001.GE	Matrix Benefit Summary
BEN: 140.001.001.GE	Matrix Benefit Summary
BEN: 145.001.001.GE	Matrix Benefit Summary
BEN: 150.001.001.GE	Matrix Benefit Summary
BEN: 155.001.001.GE	Matrix Benefit Summary
BEN: 160.001.001.GE	Matrix Benefit Summary

BEN: 165.001.001.GE	Matrix Benefit Summary
BEN: 170.001.001.GE	Matrix Benefit Summary
BEN: 175.001.001.GE	Matrix Benefit Summary
BEN: 180.001.001.GE	Matrix Benefit Summary
BEN: 185.001.001.GE	Matrix Benefit Summary
BEN: 190.001.001.GE	Matrix Benefit Summary
BEN: 195.001.001.GE	Matrix Benefit Summary
BEN: 200.001.GE	Matrix Benefit Summary
BEN: 205.001.GE	Matrix Benefit Summary
BEN: 210.001.001.GE	Matrix Benefit Summary
BEN: 215.001.001.GE	Matrix Benefit Summary
BEN: 220.001.001.GE	Matrix Benefit Summary
BEN: 225.001.GE	Matrix Benefit Summary
BEN: 230.001.GE	Matrix Benefit Summary
BEN: 235.001.GE	Matrix Benefit Summary
BEN: 275.001.GE	Matrix Benefit Summary
BEN: 280.001.GE	Matrix Benefit Summary
The following provisions/sections comprise the entire matrix certificate from TIM.CER.XX. Please note the provision/section numbers will not appear in the final, printed version of the form, but are included in the filing for informational use and reference only.	
SIG: 005.002.GE	Matrix Face Page
SIG: 015.003.GE	Matrix Face Page
SIG: 020.003.GE	Matrix Face Page
SIG: 025.003.GE	Matrix Face Page
SIG: 030.002.GE	Matrix Face Page
SIG: 040.001.GE	Matrix Face Page
SIG: 045.002.GE	Matrix Face Page
SIG: 050.001.GE	Matrix Face Page
SIG: 060.002.GE	Matrix Face Page
TOC: 005.001.GE	Matrix Table of Contents
DEF: 005.002.GE	Matrix Definition
DEF: 010.001.GE	Matrix Definition
DEF: 015.001.GE	Matrix Definition
DEF: 020.001.GE	Matrix Definition
DEF: 025.001.GE	Matrix Definition
DEF: 030.001.GE	Matrix Definition
DEF: 035.001.GE	Matrix Definition
DEF: 040.001.GE	Matrix Definition
DEF: 045.001.GE	Matrix Definition
DEF: 050.001.GE	Matrix Definition
DEF: 050.002.GE	Matrix Definition
DEF: 050.003.GE	Matrix Definition
DEF: 050.004.GE	Matrix Definition
DEF: 050.005.GE	Matrix Definition

DEF: 055.001.GE	Matrix Definition
DEF: 060.001.GE	Matrix Definition
DEF: 065.001.GE	Matrix Definition
DEF: 070.001.GE	Matrix Definition
DEF: 075.001.GE	Matrix Definition
DEF: 080.001.GE	Matrix Definition
DEF: 085.001.GE	Matrix Definition
DEF: 090.001.GE	Matrix Definition
DEF: 095.001.GE	Matrix Definition
DEF: 100.001.GE	Matrix Definition
DEF: 105.001.GE	Matrix Definition
DEF: 110.001.GE	Matrix Definition
DEF: 110.002.GE	Matrix Definition
DEF: 115.001.GE	Matrix Definition
DEF: 120.001.GE	Matrix Definition
DEF: 135.001.GE	Matrix Definition
DEF: 140.001.GE	Matrix Definition
DEF: 140.003.GE	Matrix Definition
DEF: 140.004.GE	Matrix Definition
DEF: 140.005.GE	Matrix Definition
DEF: 140.014.GE	Matrix Definition
DEF: 140.015.GE	Matrix Definition
DEF: 140.016.GE	Matrix Definition
DEF: 140.017.GE	Matrix Definition
DEF: 140.018.GE	Matrix Definition
DEF: 140.019.GE	Matrix Definition
DEF: 140.020.GE	Matrix Definition
DEF: 145.001.GE	Matrix Definition
DEF: 150.001.GE	Matrix Definition
DEF: 155.003.001.AR	Matrix Definition
DEF: 155.007.001.GE	Matrix Definition
DEF: 160.001.GE	Matrix Definition
DEF: 165.001.GE	Matrix Definition
DEF: 170.001.GE	Matrix Definition
DEF: 175.001.GE	Matrix Definition
DEF: 180.001.GE	Matrix Definition
DEF: 185.002.GE	Matrix Definition
DEF: 190.001.GE	Matrix Definition
DEF: 195.003.GE	Matrix Definition
DEF: 205.001.GE	Matrix Definition
DEF: 210.001.GE	Matrix Definition
DEF: 215.001.GE	Matrix Definition
DEF: 235.001.001.GE	Matrix Definition
DEF: 240.002.GE	Matrix Definition

DEF: 250.001.GE	Matrix Definition
DEF: 255.001.GE	Matrix Definition
DEF: 260.001.GE	Matrix Definition
DEF: 265.001.GE	Matrix Definition
DEF: 270.001.GE	Matrix Definition
DEF: 275.001.GE	Matrix Definition
DEF: 280.001.GE	Matrix Definition
DEF: 285.001.GE	Matrix Definition
DEF: 290.001.GE	Matrix Definition
DEF: 295.001.GE	Matrix Definition
DEF: 305.001.GE	Matrix Definition
DEF: 310.001.GE	Matrix Definition
DEF: 315.001.GE	Matrix Definition
DEF: 320.001.GE	Matrix Definition
DEF: 325.001.GE	Matrix Definition
DEF: 330.001.GE	Matrix Definition
DEF: 335.001.GE	Matrix Definition
DEF: 335.002.GE	Matrix Definition
DEF: 335.003.GE	Matrix Definition
DEF: 335.004.GE	Matrix Definition
DEF: 335.005.GE	Matrix Definition
DEF: 335.006.GE	Matrix Definition
DEF: 335.007.GE	Matrix Definition
DEF: 335.008.GE	Matrix Definition
DEF: 340.001.GE	Matrix Definition
DEF: 345.001.GE	Matrix Definition
DEF: 350.001.GE	Matrix Definition
DEF: 355.001.GE	Matrix Definition
DEF: 360.001.GE	Matrix Definition
DEF: 365.001.GE	Matrix Definition
DEF: 370.001.GE	Matrix Definition
DEF: 375.001.GE	Matrix Definition
DEF: 380.001.GE	Matrix Definition
DEF: 385.001.GE	Matrix Definition
DEF: 390.001.GE	Matrix Definition
DEF: 395.001.GE	Matrix Definition
DEF: 400.001.001.GE	Matrix Definition
DEF: 405.001.GE	Matrix Definition
DEF: 410.001.GE	Matrix Definition
DEF: 415.001.GE	Matrix Definition
DEF: 420.001.GE	Matrix Definition
DEF: 425.001.GE	Matrix Definition
DEF: 435.001.GE	Matrix Definition
DEF: 440.001.GE	Matrix Definition

DEF: 445.001.GE	Matrix Definition
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DEF: 455.001.GE	Matrix Definition
DEF: 460.001.GE	Matrix Definition
DEF: 465.001.GE	Matrix Definition
DEF: 475.001.GE	Matrix Definition
DEF: 480.001.GE	Matrix Definition
DEF: 485.001.GE	Matrix Definition
DEF: 490.001.GE	Matrix Definition
DEF: 495.001.GE	Matrix Definition
DEF: 500.002.001.GE	Matrix Definition
DEF: 505.001.GE	Matrix Definition
DEF: 515.001.GE	Matrix Definition
DEF: 520.001.GE	Matrix Definition
DEF: 525.001.GE	Matrix Definition
DEF: 530.001.GE	Matrix Definition
DEF: 535.001.GE	Matrix Definition
DEF: 540.003.GE	Matrix Definition
DEF: 555.001.GE	Matrix Definition
DEF: 560.001.GE	Matrix Definition
DEF: 565.001.GE	Matrix Definition
DEF: 570.001.GE	Matrix Definition
DEF: 570.002.GE	Matrix Definition
DEF: 575.001.GE	Matrix Definition
DEF: 580.001.GE	Matrix Definition
DEF: 585.001.GE	Matrix Definition
DEF: 590.001.GE	Matrix Definition
DEF: 595.001.GE	Matrix Definition
DEF: 600.001.GE	Matrix Definition
DEF: 605.002.GE	Matrix Definition
DEF: 610.002.GE	Matrix Definition
DEF: 615.001.GE	Matrix Definition
DEF: 620.001.GE	Matrix Definition
DEF: 625.001.GE	Matrix Definition
DEF: 630.001.GE	Matrix Definition
DEF: 635.001.GE	Matrix Definition
DEF: 640.001.GE	Matrix Definition
DEF: 645.001.GE	Matrix Definition
DEF: 650.001.GE	Matrix Definition
DEF: 655.001.GE	Matrix Definition
DEF: 660.001.GE	Matrix Definition
DEF: 665.001.GE	Matrix Definition
DEF: 670.001.GE	Matrix Definition
DEF: 675.001.GE	Matrix Definition

DEF: 680.001.GE	Matrix Definition
DEF: 685.001.GE	Matrix Definition
DEF: 690.001.GE	Matrix Definition
DEF: 695.001.GE	Matrix Definition
DEF: 700.001.GE	Matrix Definition
DEF: 705.001.GE	Matrix Definition
DEF: 710.001.GE	Matrix Definition
DEF: 715.001.GE	Matrix Definition
DEF: 720.001.GE	Matrix Definition
DEF: 725.001.GE	Matrix Definition
DEF: 730.001.GE	Matrix Definition
DEF: 735.001.GE	Matrix Definition
DEF: 740.001.GE	Matrix Definition
DEF: 745.001.GE	Matrix Definition
DEF: 750.001.GE	Matrix Definition
DEF: 755.001.GE	Matrix Definition
DEF: 760.001.GE	Matrix Definition
DEF: 765.001.GE	Matrix Definition
DEF: 770.001.GE	Matrix Definition
DEF: 775.001.GE	Matrix Definition
DEF: 780.001.GE	Matrix Definition
DEF: 785.001.GE	Matrix Definition
DEF: 790.001.GE	Matrix Definition
DEF: 795.001.GE	Matrix Definition
DEF: 800.001.GE	Matrix Definition
EFF: 005.002.GE	Certificate Holder Effective Date
EFF: 010.008.GE	Certificate Holder Effective Date
EFF: 015.001.AR	Certificate Holder Effective Date
EFF: 020.004.GE	Certificate Holder Effective Date
URP: 005.002.GE	Utilization Review
PAR: 005.013.GE	Provider Charges and Provisions
PAR: 005.014.GE	Provider Charges and Provisions
PAR: 005.015.GE	Provider Charges and Provisions
PAR: 005.016.GE	Provider Charges and Provisions
PAR: 005.017.GE	Provider Charges and Provisions
PAR: 005.018.GE	Provider Charges and Provisions
PAR: 005.019.GE	Provider Charges and Provisions
PAR: 005.020.GE	Provider Charges and Provisions
PAR: 005.021.GE	Provider Charges and Provisions
PAR: 005.022.GE	Provider Charges and Provisions
PAR: 005.023.GE	Provider Charges and Provisions
PAR: 005.024.GE	Provider Charges and Provisions
PAR: 010.001.001.GE	Provider Charges and Provisions
MED: 005.002.GE	Medical Benefits

MED: 010.001.AR	Medical Benefits
MED: 015.001.GE	Medical Benefits
MED: 020.001.GE	Medical Benefits
MED: 025.001.GE	Medical Benefits
MED: 026.002.AR	Medical Benefits
MED: 027.002.AR	Medical Benefits
MED: 030.001.GE	Medical Benefits
MED: 040.001.GE	Medical Benefits
MED: 045.001.GE	Medical Benefits
MED: 050.001.GE	Medical Benefits
MED: 055.001.GE	Medical Benefits
MED: 065.001.001.GE	Medical Benefits
MED: 070.001.GE	Medical Benefits
MED: 075.001.001.GE	Medical Benefits
MED: 080.001.AR	Medical Benefits
MED: 085.001.GE	Medical Benefits
MED: 090.001.GE	Medical Benefits
MED: 095.001.GE	Medical Benefits
MED: 100.001.GE	Medical Benefits
MED: 105.001.GE	Medical Benefits
MED: 110.001.GE	Medical Benefits
MED: 115.001.GE	Medical Benefits
MED: 120.001.GE	Medical Benefits
MED: 125.001.GE	Medical Benefits
MED: 130.001.GE	Medical Benefits
MED: 135.001.GE	Medical Benefits
MED: 140.001.GE	Medical Benefits
MED: 145.001.GE	Medical Benefits
MED: 150.001.GE	Medical Benefits
MED: 155.001.GE	Medical Benefits
MED: 160.001.GE	Medical Benefits
MED: 165.001.GE	Medical Benefits
MED: 170.001.GE	Medical Benefits
MED: 175.001.GE	Medical Benefits
MED: 180.002.GE	Medical Benefits
MED: 185.002.GE	Medical Benefits
MED: 190.001.GE	Medical Benefits
MED: 195.001.AR	Medical Benefits
MED: 200.001.GE	Medical Benefits
MED: 205.001.GE	Medical Benefits
MED: 215.001.GE	Medical Benefits
MED: 220.001.GE	Medical Benefits
MED: 225.001.GE	Medical Benefits
MED: 230.001.GE	Medical Benefits

MED: 235.001.GE	Medical Benefits
MED: 240.001.GE	Medical Benefits
MED: 245.001.GE	Medical Benefits
MED: 250.001.GE	Medical Benefits
MED: 265.001.GE	Medical Benefits
MED: 275.001.GE	Medical Benefits
MED: 280.001.GE	Medical Benefits
RXP: 005.002.001.AR	Outpatient Prescription Drug Benefits
RXP: 010.001.GE	Outpatient Prescription Drug Benefits
RXP: 015.001.GE	Outpatient Prescription Drug Benefits
LIF: 005.001.GE	Life Insurance Benefits
LIF: 010.001.001.GE	Life Insurance Benefits
EXC: 005.002.GE	Exclusions
EXC: 010.001.GE	Exclusions
EXC: 015.001.GE	Exclusions
EXC: 020.001.GE	Exclusions
EXC: 025.001.GE	Exclusions
EXC: 030.001.GE	Exclusions
EXC: 035.001.GE	Exclusions
EXC: 040.001.GE	Exclusions
EXC: 045.001.GE	Exclusions
EXC: 050.001.GE	Exclusions
EXC: 055.001.GE	Exclusions
EXC: 060.001.GE	Exclusions
EXC: 065.001.GE	Exclusions
EXC: 070.001.GE	Exclusions
EXC: 075.001.GE	Exclusions
EXC: 080.001.GE	Exclusions
EXC: 085.001.GE	Exclusions
EXC: 090.001.GE	Exclusions
EXC: 095.001.GE	Exclusions
EXC: 100.001.GE	Exclusions
EXC: 105.001.GE	Exclusions
EXC: 110.001.001.GE	Exclusions
EXC: 115.001.GE	Exclusions
EXC: 120.001.GE	Exclusions
EXC: 125.001.AR	Exclusions
EXC: 130.001.GE	Exclusions
EXC: 135.001.GE	Exclusions
EXC: 140.001.GE	Exclusions
EXC: 145.001.AR	Exclusions
EXC: 150.001.GE	Exclusions
EXC: 155.001.GE	Exclusions
EXC: 160.001.GE	Exclusions

EXC: 165.001.GE	Exclusions
EXC: 170.001.GE	Exclusions
EXC: 175.001.001.GE	Exclusions
EXC: 180.001.GE	Exclusions
EXC: 185.001.GE	Exclusions
EXC: 190.001.GE	Exclusions
EXC: 195.001.GE	Exclusions
EXC: 200.001.GE	Exclusions
EXC: 205.001.GE	Exclusions
EXC: 210.001.GE	Exclusions
EXC: 215.001.GE	Exclusions
EXC: 220.001.GE	Exclusions
EXC: 225.001.GE	Exclusions
EXC: 230.001.GE	Exclusions
EXC: 235.001.GE	Exclusions
EXC: 240.001.001.GE	Exclusions
EXC: 245.001.GE	Exclusions
EXC: 250.001.GE	Exclusions
EXC: 255.001.GE	Exclusions
EXC: 260.001.GE	Exclusions
EXC: 265.001.GE	Exclusions
EXC: 270.001.GE	Exclusions
EXC: 275.001.GE	Exclusions
EXC: 280.001.GE	Exclusions
EXC: 285.001.GE	Exclusions
EXC: 290.001.GE	Exclusions
EXC: 295.001.GE	Exclusions
EXC: 300.001.001.GE	Exclusions
EXC: 325.001.GE	Exclusions
EXC: 330.001.GE	Exclusions
EXC: 335.001.GE	Exclusions
EXC: 340.001.GE	Exclusions
EXC: 345.001.GE	Exclusions
EXC: 350.001.GE	Exclusions
EXC: 355.001.GE	Exclusions
EXC: 360.001.GE	Exclusions
EXC: 365.001.GE	Exclusions
EXC: 370.001.GE	Exclusions
EXC: 375.001.GE	Exclusions
EXC: 380.001.GE	Exclusions
EXC: 385.001.GE	Exclusions
EXC: 390.001.GE	Exclusions
EXC: 395.001.GE	Exclusions
EXC: 400.001.GE	Exclusions

EXC: 405.001.GE	Exclusions
EXC: 410.001.GE	Exclusions
EXC: 415.001.GE	Exclusions
EXC: 420.001.GE	Exclusions
EXC: 425.001.GE	Exclusions
EXC: 430.001.GE	Exclusions
EXC: 435.001.GE	Exclusions
EXC: 440.001.GE	Exclusions
EXC: 445.001.GE	Exclusions
EXC: 450.001.GE	Exclusions
EXC: 455.001.GE	Exclusions
EXC: 460.001.GE	Exclusions
EXC: 465.001.GE	Exclusions
EXC: 470.001.GE	Exclusions
EXC: 475.001.GE	Exclusions
EXC: 480.001.GE	Exclusions
EXC: 485.001.GE	Exclusions
PRX: 005.002.GE	Pre-Existing Conditions Limitations
PRX: 010.002.GE	Pre-Existing Conditions Limitations
PRX: 020.001.GE	Pre-Existing Conditions Limitations
COB: 005.002.GE	Coordination of Benefits
CLP: 005.002.GE	Claims Provisions
CLP: 010.002.GE	Claims Provisions
CLP: 015.001.GE	Claims Provisions
CLP: 020.001.GE	Claims Provisions
CLP: 025.001.GE	Claims Provisions
CLP: 035.001.GE	Claims Provisions
CLP: 040.001.GE	Claims Provisions
CLP: 045.001.GE	Claims Provisions
PRE: 005.002.GE	Premium Provisions
PRE: 010.002.GE	Premium Provisions
PRE: 015.001.GE	Premium Provisions
PRE: 025.002.GE	Premium Provisions
PRE: 025.003.GE	Premium Provisions
PRE: 030.001.001.GE	Premium Provisions
REC: 005.002.GE	Recovery Provisions
REC: 010.001.GE	Recovery Provisions
REC: 015.001.GE	Recovery Provisions
REC: 020.001.GE	Recovery Provisions
REC: 025.001.GE	Recovery Provisions
CNV: 005.002.GE	Conversion
CNV: 005.005.GE	Conversion
CNV: 005.006.GE	Conversion
CNV: 015.002.GE	Conversion

OTH: 005.002.GE	Other Provisions
OTH: 010.002.GE	Other Provisions
OTH: 015.002.GE	Other Provisions
OTH: 020.001.GE	Other Provisions
OTH: 021.002.AR	Other Provisions
OTH: 025.001.GE	Other Provisions
OTH: 030.002.GE	Other Provisions
OTH: 035.001.GE	Other Provisions
OTH: 035.004.GE	Other Provisions
OTH: 040.002.GE	Other Provisions
OTH: 041.001.GE	Other Provisions
OTH: 041.002.GE	Other Provisions
OTH: 041.003.GE	Other Provisions
OTH: 045.001.GE	Other Provisions
OTH: 055.003.GE	Other Provisions
OTH: 060.001.GE	Other Provisions
OTH: 065.001.GE	Other Provisions
OTH: 075.003.GE	Other Provisions

BENEFIT SUMMARY

[POLICYHOLDER INFORMATION]

[POLICYHOLDER]	**[ABC Trust/Association]**
[LOCATION]	**[City/State]**

[CERTIFICATE HOLDER] INFORMATION

[CERTIFICATE HOLDER] [Dependents]	[John Doe] [Jane Doe] [Mary Doe] [James Doe]
[CERTIFICATE NUMBER]	[0000001]
[EFFECTIVE DATE] [of this schedule]	[00/00/0000]
[PLAN ID] [PLAN TYPE]	[Plan name inserted here – CoreMed, MaxPlan, etc.]
[PARTICIPATING EMPLOYER]	[ABC Company]
[GROUP NUMBER]	[1900AK0000]
[LOCATION NUMBER]	[001]
[BENEFIT PERIOD]	[35 days]
[BENEFIT PERIOD TERMINATION DATE]	[05/05/2006]
[PAYMENT OPTION]	[Single Payment][Monthly Payment]
[[BENEFIT] WAITING PERIOD]	[3 days from Effective Date for Sickness]

This Summary contains limited information about Your plan. PLEASE READ YOUR CERTIFICATE CAREFULLY TO UNDERSTAND YOUR COVERAGE.

The Utilization Review Provisions [and the [Select Participating Provider Network] [Select Network] [Participating Provider Network] [Network Provider] [Network]] must be utilized, to be eligible to receive the maximum benefits available under the policy. Refer to the Utilization Review Provisions for the medical benefits that must be reviewed.

Major Medical Benefits for [Single Plan/Family Plan] [Certificate Holder-Spouse Plan] [Certificate Holder-Children Plan].

[The [Select Participating Provider Network] [Select Network] [Participating Provider Network] [Network Provider is [PPO].]

Benefits will be paid for Covered Charges Incurred while coverage is in force. Payment of benefits will be subject to all benefit provisions and other conditions of the plan. The benefits listed in this schedule are for each Covered Person unless otherwise indicated.

[[BENEFIT PERIOD] [MAXIMUM [LIFETIME] BENEFIT]] [for each [Covered Person] [Family] [Accident] [Injury] [Sickness]]	[$100,000 - $100,000,000]
[CALENDAR YEAR MAXIMUM BENEFIT] [for each [Covered Person] [Family] [Accident] [Injury] [Sickness]]	[$25,000 - $500,000]
[[ACCIDENT] [SICKNESS] MAXIMUM BENEFIT] [for each [Covered Person] [Family] [Accident] [Injury] [Sickness]]	[$500 - $5,000]

[**DAILY MAXIMUM BENEFIT**] [for each [Covered Person] [Family] [Accident] [Injury] [Sickness]]	[$100 - $10,000]
[**PLAN YEAR MAXIMUM BENEFIT**] [for each [Covered Person] [Family] [Accident] [Injury] [Sickness]]	[$25,000 - $500,000]
[**PER CAUSE MAXIMUM BENEFIT**] [for each [Covered Person] [Family]]	[$1,000 - $200,000]
[**OUTPATIENT [CALENDAR YEAR] [PLAN YEAR] [BENEFIT PERIOD] [TIME PERIOD] MAXIMUM BENEFIT**] [for each [Covered Person] [Family]]	[$1,000 - $50,000]
[**MONTHLY MAXIMUM BENEFIT**] [for each [Covered Person] [Family]]	[$1.000 - $50,000]

BEN: 005.001.001.GE

PLAN DEDUCTIBLES

[[Annual]Carryover Deductible]
Covered Charges Incurred by a Covered Person [due to an Accident] [for Inpatient services] [for Inpatient services received on December 31st of a Calendar Year] [during the last [3] months of a [Plan Year] [Calendar Year] [Benefit Period]] that count toward satisfying a Covered Person's [Individual Deductible,] [Integrated Deductible] [or] [Non-Participating][Non-Network] Provider Deductible,] [but do not satisfy the [Network] [Participating] Provider Deductible] [Individual Out-of-Pocket Limit] for that [Plan Year,] [Calendar Year,] [Benefit Period,] will also count toward satisfying the Covered Person's [Individual Deductible] [or] [Non-Participating][Non-Network] Provider Deductible] for the next [Plan Year] [Calendar Year] [Benefit Period]. [This Carryover Deductible [does not count toward satisfying the [maximum] Family Deductible] [and] [only applies in the first [Plan Year] [Calendar Year] [Benefit Period].] [For the purpose of determining whether a Carryover Deductible applies, Covered Charges will be considered to apply toward the [Individual Deductible] [or] [Non-Participating][Non-Network] Provider Deductible] in the order the Covered Charges are processed.]]

[The [Select Network,] [Network] and [[Non-Network] [Non-Participating Provider]] Deductibles are calculated separately.] [[For example,] Amounts applied toward Your [Select Network] Deductible will not be credited toward Your [Network] Deductible, and amounts credited toward Your [[Non-Network] [Non-Participating Provider]] Deductible will not be credited toward Your [Network] Deductible.]

[All Deductibles are calculated separately. Applicable Deductibles must be satisfied prior to any payment of Covered Charges.]

[Deductibles may apply to specific types of services. Please review the Benefit Summary for additional Deductible information.]

	[[Select] Participating Provider Benefits / [Select] Network]	**[Participating Provider Benefits / Network Provider Benefits]**	**[Non-[Select] Participating Provider Benefits/Non-Participating Provider Benefits/ Non-Network Provider Benefits]**
Individual Plan Deductible [*] [each] [every] [XX] [Calendar Year[s]] [Benefit Period[s]] [Per Cause] [Time Period[s]] [Plan Year[s]]	[None / $0 - $30,000]	[None / $0 - $30,000]	[$0 - $30,000]
[[Maximum] [Family] Plan [Integrated] [Per Cause] Deductible][*] [each] [every [XX]] [Calendar Year[s]] [Benefit Period[s]] [Per Cause] [Time Period[s]] [Plan Year[s]]	[None / $0 - $30,000]	[None / $0 - $30,000]	[None / $0 - $30,000]
[[Maximum] [Common][Accident] [Per Cause] Deductible][*] [each] [every [XX]] [Calendar Year[s]] [Benefit Period[s]] [Per Cause] [Time	[None / $0 - $30,000]	[None / $0 - $30,000]	[None / $0 - $30,000]

Period[s]] [Plan Year[s]]			
[Non-Participating] [Non-Network] Provider Deductible is in addition to the [Participating] [Network] Provider Deductible.]			
[Once [[2] or more Covered Persons have collectively met] the maximum Family Deductible [has been met], no additional Deductible will be taken during the [XX] [Calendar Year[s]] [Plan Year[s]] [Benefit Period[s]] [Time Period[s]].]			

[* We may adjust this amount periodically to ensure that it is not less than the [minimum] [maximum] amount permitted by federal law.]

BEN: 010.001.001.GE

[[Deductible] [Credit] [Reward] [Multi Year Deductible] Program:]
[[DEDUCTIBLE] [CREDIT] [REWARD] [MULTI YEAR DEDUCTIBLE] PROGRAM EFFECTIVE DATE] [00/00/0000]
[[DEDUCTIBLE] [CREDIT] [REWARD] [MULTI YEAR DEDUCTIBLE] PROGRAM TERMINATION DATE] [00/00/0000]
[[Amounts may be credited to Your Deductibles based on the [Deductible] [Credit] [and] [or] [Reward] [and] [or] [Multi Year Deductible] Program.] [At no time will Your [Individual] [Family] [Integrated] [and] [Network] [Participating][,][and] [Non-Network] [Non-Participating] Deductible less any accumulated [credits] [and] [or] [reward] [and] [or] [Multi Year Deductible] be less than [$XXX][or the minimum HSA-Qualified deductible amount for HSA-Qualified plans].]]

BEN: 010.002.GE

[Plan] Coinsurance] [and] [[Total] [Plan] Out-of-Pocket Limits] [The Coinsurance is listed below unless specified elsewhere in the Benefit Summary]			
[Once the [Total] Out-of-Pocket limit is met the plan pays at [100%][unless otherwise specified]]			
[The Out-of-Pocket maximums for [Select Participating Providers,] [Select Network,] [Participating Providers,] [Network Provider] [and] [[Non-Participating] [Non-Network] Providers] are calculated separately. [For example,] Amounts credited toward Your [Participating][Network] Provider Out-of-Pocket maximum will [not] be credited toward Your Non-Participating Provider[Non-Network] Out-of-Pocket maximum, and amounts credited toward Your [Non-Participating] [Non-Network] Provider Out-of-Pocket maximum will [not] be credited toward Your [Participating] [Network] Provider Out-of-Pocket maximum.]			
[All Out-of-Pocket Limits are calculated separately. Applicable Out-of-Pocket Limits must be satisfied prior to any payment of Covered Charges. [Out-of-Pocket Limits do not include Deductible.]			
[[Coinsurance] [and] [Out-of--Pocket Limits] may apply to specific types of services. Please review the Benefit Summary for additional [Coinsurance] [and] [Out-of--Pocket Limits] information.]			
[Any applicable Prescription Drug Deductible, Coinsurance, Copayment [or Ancillary Charge] are calculated separately from the Plan Out-of-Pocket and do not count toward the plan Out-of-Pocket.]			
	[[Select] Participating Provider [Benefits]/ [Select] Network]]	**[Participating Provider [Benefits] / Network Provider [Benefits]]**	**[Non-[Select] Participating Provider [Benefits]/ Non-Participating Provider [Benefits]/ Non-Network Provider [Benefits]]**
[Tier [1]] [*] [Plan] [Coinsurance]	[[0% - 100%] [until the [Plan] [Tier [1]] Out-of-Pocket Limits are satisfied; [then Tier [2];] [100% thereafter.]]	[[0% - 100%] [until the [Plan] [Tier [1]] Out-of-Pocket Limits are satisfied; [then Tier [2];] [100% thereafter.]]	[[0% - 100%] [until the [Plan] [Tier [1]] Out-of-Pocket Limits are satisfied; [then Tier [2];] [100% thereafter.]]
[Tier [1]][*] [Out-of-Pocket Limit] [each [Calendar Year] [Benefit Period] [Time Period] [Plan Year] [Individual][*]	[$0 - $50,000 / Not applicable]	[$0 - $50,000 / Not applicable]	[$0 - $50,000 / an additional $0 - $10,000]

[Family][*]	[$0 - $150,000 / Not applicable]	[$0 - $150,000 / Not applicable]	[$0 - $150,000 / an additional $0 - $30,000]
[Tier [2]][*] [Plan] [Coinsurance]	[[0% - 100%] [until the [Plan] [Tier [2]] Out-of-Pocket Limits are satisfied; [then Tier [X];] [100% thereafter.]]	[[0% - 100%] [until the [Plan] [Tier [2]] Out-of-of-Pocket Limits are satisfied; [then Tier [X];] [100% thereafter.]]	[[0% - 100%] [until the [Plan] [Tier [2]] Out-of-Pocket Limits are satisfied; [then Tier [X];] [100% thereafter.]]
[Tier [2]][*] [Out-of-Pocket Limit] [each [Calendar Year] [Benefit Period] [Time Period] [Plan Year] [Individual][*]	[$0 - $50,000 / Not applicable]	[$0 - $50,000 / Not applicable]	[$0 - $50,000 / an additional $0 - $10,000]
[Family][*]	[$0 - $150,000 / Not applicable]	[$0 - $150,000 / Not applicable]	[$0 - $150,000 / an additional $0 - $30,000]
[Tier [X]][*] [Plan][Coinsurance]	[[0% - 100%] [until the [Plan] [Tier [X]] Out-of-Pocket Limits are satisfied; [then Tier [X + [1];] [100% thereafter.]]	[[0% - 100%] [until the [Plan] [Tier [X]] Out-of-of-Pocket Limits are satisfied; [then Tier [X + [1];] [100% thereafter.]]	[[0% - 100%] [until the [Plan] [Tier X]] Out-of-Pocket Limits are satisfied; [then Tier [X + [1];] [100% thereafter.]]
[Tier [X]][*] [Out-of-Pocket Limit] [each [Calendar Year] [Benefit Period] [Time Period] [Plan Year] [Individual][*]	[$0 - $25,000 / Not applicable]	[$0 - $25,000 / Not applicable]	[$0 - $25,000 / an additional $0 - $10,000]
[Family][*]	[$0 - $75,000 / Not applicable]	[$0 - $75,000 / Not applicable]	[$0 - $75,000 / an additional $0 - $30,000]
[Total] [Plan] [Out-of-Pocket (OOP) Limits][*]			
[Individual Out-of-Pocket Limit each [Calendar Year] [Plan Year][Benefit Period][*]	[$0 - $25,000 / Not applicable]	[$0 - $25,000 / Not applicable]	[$0 - $25,000 / an additional $0 - $10,000]
[Common] [Family Out-of-Pocket Limit each [Calendar Year] [Plan Year][Benefit Period][*]	[$0 - $75,000 / Not applicable]	[$0 - $75,000 / Not applicable]	[$0 - $75,000 / an additional $0 - $30,000]
[Total][Out-of-Pocket (OOP) Limits each [Calendar Year] [Plan Year][*]			[$0 - $25,000]
[[All Out-of-Pocket Limits are calculated separately.] [Applicable Out-of-Pocket Limits must be satisfied prior to any payment of Covered Charges.] [Out-of-Pocket Limits do not include Deductible.] [Amounts may be credited to Your Out-of-Pocket Limits based on the Deductible [Credit] [and] [or] [Reward] [and] [or] [Multi Year Deductible] Program.]]			

[* We may adjust this amount periodically to ensure that it is not less than the [minimum] [maximum] amount permitted by federal law.]

BEN: 015.001.001.GE

[**Inpatient Medical Facility Services**]:				
[Subject to [Plan] [Integrated] [Per Cause] Deductible] and [Plan] Coinsurance [unless otherwise specified]]				
[Benefits are limited to a Maximum [Lifetime] [Calendar Year] [Plan Year] [Benefit Period] [Per Cause] [Monthly] [Daily] Benefit of [$XXX] [unless due to an [Accidental Injury] [Injury] [or] [underlying Sickness] [then We will pay up to a [$XXX] Maximum [Lifetime] [Calendar Year] [Plan Year] [Benefit Period] [Per Cause] [Monthly] [Daily] Benefit]				
	[Participating Provider [Benefits] / Network Provider [Benefits]]	**[[Select] Participating Provider [Benefits]]**	**[Participating Provider [Benefits] / Network Provider [Benefits]]**	**[Non-[Select] Participating Provider [Benefits]/ Non-Participating Provider [Benefits]/ Non-Network Provider [Benefits]]**
[[Inpatient Medical Facility Services] Maximum Benefit]	[$XXX] [Per Covered Person]	[$XXX] [Per Covered Person]	[$XXX] [Per Covered Person]	[$XXX] [Per Covered Person]
[[Inpatient Medical Facility Services] Maximum Benefit] [due to an [Accidental Injury] [Injury] [or] [underlying Sickness]	$XXX] [Per Covered Person	$XXX] [Per Covered Person]	[$XXX] [Per Covered Person]	[$XXX] [Per Covered Person]
[[Inpatient Medical Facility Services Deductible] [each [Calendar Year] [Benefit Period] [Time Period] [Plan Year] [Individual] [Integrated] [Family]	 [$XXX] [$XXX]	 [$XXX] [$XXX]	 [$XXX] [$XXX]	 [$XXX] [$XXX]
[The [Inpatient Medical Facility Services Deductible] does [not] apply to the [Plan] [Integrated] [Per Cause] Deductible or Total [Plan] Out-of-Pocket Limits.]				
[[Non-Participating] [Non-Network] Provider Deductible is in addition to the Participating Provider Deductible.]				
[[Emergency Room Copayment applies only to the Emergency Room charges.] [Once this amount is paid, We will pay the remaining Emergency Room charge at [100%].] [All other covered charges associated with the Emergency Room visit will be subject to the [Plan] [Integrated] [Per Cause] [and] [Inpatient Medical Facility Services] [Deductible] and [Plan] [and] [Inpatient Medical Facility Services] Coinsurance [unless otherwise specified.]]				
[Once [[2] or more Covered Persons have collectively met] the maximum Family Deductible [has been met]], no additional Deductible will be taken during the [Calendar Year] [Plan Year] [Benefit Period] [Time Period].]				
[[Facility] [Copayment]]	[None / $XXX per Inpatient confinement]	[None / $XXX per Inpatient confinement]	[None / $XXX per Inpatient confinement]	[None / $XXX per Inpatient confinement]
[Facility] [Access] [Fee]	[[$XXX] per Inpatient confinement] [Per Day] [up to [xx] days]]	[[$XXX] per Inpatient confinement] [Per Day] [up to [xx] days]]	[[$XXX] per Inpatient confinement] [Per Day] [up to [xx] days]]	[[$XXX] per Inpatient confinement] [Per Day] [up to [xx] days]]
[Emergency Room] [Access] [Fee]	[[$XXX] per Emergency Room visit] [Waived if admitted]	[[$XXX] per Emergency Room visit] [Waived if	[[$XXX] per Emergency Room visit] [Waived if admitted]	[[$XXX] per Emergency Room visit] [Waived if admitted]

		admitted]		
[Emergency Room] [Copayment]	[[$XXX] per Emergency Room visit] [Waived if admitted]	[[$XXX] per Emergency Room visit] [Waived if admitted]	[[$XXX] per Emergency Room visit] [Waived if admitted]	[Subject to [Plan] [and] [Outpatient] [Integrated] [Per Cause] Deductible] and [Plan] [and] [Outpatient] Coinsurance [unless otherwise specified].]
[Inpatient Medical Facility Services] [Coinsurance] [Tier [1]]	[0% - 100% [until the [Inpatient Medical Facility Services] [Tier [1]] Out-of-Pocket Limits are satisfied; [then Tier [2];] [100% thereafter.]]	[0% - 100% [until the [Inpatient Medical Facility Services] [Tier [1]] Out-of-Pocket Limits are satisfied; [then Tier [2];] [100% thereafter.]]	[0% - 100% [until the [Inpatient Medical Facility Services] [Tier [1]] Out-of-Pocket Limits are satisfied; [then Tier [2];] [100% thereafter.]]	[0% - 100% [until the [Inpatient Medical Facility Services] [Tier [1]] Out-of-Pocket Limits are satisfied; [then Tier [2];] [100% thereafter.]]
[Tier [1]] [Inpatient Medical Facility Services] [Out-of-Pocket Limit] [each [Calendar Year] [Benefit Period] [Time Period] [Plan Year] [Individual] [Family]	[$0 - $25,000 / Not applicable] [$0 - $75,000 / Not applicable]	[$0 - $25,000 / Not applicable] [$0 - $75,000 / Not applicable]	[$0 - $25,000 / Not applicable] [$0 - $75,000 / Not applicable]	[$0 - $25,000 / an additional $0 - $10,000] [$0 - $75,000 / an additional $0 - $30,000]
[Inpatient Medical Facility Services] [Coinsurance] [Tier [2]]	[0% - 100% [until the [Inpatient Medical Facility Services] [Tier [2]] Out-of-Pocket Limits are satisfied; [then Tier [X];] [100% thereafter.]]	[0% - 100% [until the [Inpatient Medical Facility Services] [Tier [2]] Out-of-Pocket Limits are satisfied; [then Tier [X];] [100% thereafter.]]	[0% - 100% [until the [Inpatient Medical Facility Services] [Tier [2]] Out-of-Pocket Limits are satisfied; [then Tier [X];] [100% thereafter.]]	[0% - 100% [until the [Inpatient Medical Facility Services] [Tier [2]] Out-of-Pocket Limits are satisfied; [then Tier [X];] [100% thereafter.]]
[Tier [2]] [Inpatient Medical Facility Services] [Out-of-Pocket Limit][each [Calendar Year] [Benefit Period] [Time Period] [Plan Year] [Individual] [Family]	[$0 - $25,000 / Not applicable] [$0 - $75,000 / Not applicable]	[$0 - $25,000 / Not applicable] [$0 - $75,000 / Not applicable]	[$0 - $25,000 / Not applicable] [$0 - $75,000 / Not applicable]	[$0 - $25,000 / an additional $0 - $10,000] [$0 - $75,000 / an additional

				$0 - $30,000]
[Inpatient Medical Facility Services] [Coinsurance] [Tier [X]]	[0% - 100% [until the [Inpatient Medical Facility Services] [Tier [X]] Out-of-Pocket Limits are satisfied;] [then Tier [X + [1]];] [100% thereafter.]]	[0% - 100% [until the [Inpatient Medical Facility Services] [Tier [X]] Out-of-Pocket Limits are satisfied;] [then Tier [X + [1]];] [100% thereafter.]]	[0% - 100% [until the [Inpatient Medical Facility Services] [Tier [X]] Out-of-Pocket Limits are satisfied;] [then Tier [X + [1]];] [100% thereafter.]]	[0% - 100% [until the [Inpatient Medical Facility Services] [Tier [X]] Out-of-Pocket Limits are satisfied;] [then Tier [X + [1]];] [100% thereafter.]]
[Tier [X]] [Inpatient Medical Facility Services] [Out-of-Pocket Limit][each [Calendar Year] [Benefit Period] [Time Period] [Plan Year] [Individual] [Family]	 [$0 - $25,000 / Not applicable] [$0 - $75,000 / Not applicable]	 [$0 - $25,000 / Not applicable] [$0 - $75,000 / Not applicable]	 [$0 - $25,000 / Not applicable] [$0 - $75,000 / Not applicable]	 [$0 - $25,000 / an additional $0 - $10,000] [$0 - $75,000 / an additional $0 - $30,000]
[[Inpatient Medical Facility Services] [Out-of-Pocket Limits] [each] [Calendar Year] [Benefit Period] [Time Period] [Plan Year] [Individual] [Family]	 [$XXX] [$XXX]	 [$XXX] [$XXX]	 [$XXX] [$XXX]	 [$XXX] [$XXX]

BEN: 020.001.GE

[**Outpatient Medical Facility Services**:]
[All Outpatient services, supplies and treatments apply to the [Outpatient] [Plan Year] [Per Cause] [Calendar Year] Maximum Benefit [including] [excluding] Outpatient Prescription Drugs.]
[Limited to Outpatient Services associated with an Inpatient Stay when Covered Charges are Incurred within [14 days] of admission.]
[Subject to [Plan] [and] [Outpatient Services] [Integrated] [Per Cause] Deductible] and [Plan] [and] [Outpatient Services] [Outpatient] Coinsurance [unless otherwise specified]]
[Benefits are limited to an Outpatient [Calendar Year] Maximum [Lifetime] [Calendar Year] [Plan Year] [Benefit Period] [Per Cause] [Monthly] [Daily] Benefit of [$XXX] per [Covered Person] [covered child] [Family] [unless due to an] [Accidental Injury] [Injury] [or] [underlying Sickness] [then We will pay up to a[$XXX] Maximum [Lifetime] [Calendar Year] [Plan Year] [Benefit Period] [Per Cause] [Monthly] [Daily] Benefit]]
[We will pay [up to] an Outpatient Maximum of [$XXX] [per][Covered Person] [covered child] per [day] [episode] [unless due to an [Accidental Injury] [Injury] [or] [underlying Sickness] [then We will pay up to [$XXX] per [day] [episode]]

[Emergency Room] Benefits are limited to a [Lifetime] [Calendar Year] [Plan Year] [Benefit Period] [Per Cause] [Monthly] [Daily] [per] [episode] Maximum Benefit of [$XXX] [per] [Covered Person] [covered child] [Family]]			
[The [Emergency Room] [Access] [Fee] [Copayment] will [not] apply toward any Out-of-Pocket Limit]			
[The [Emergency Room] [Access] [Fee] [Copayment] will be waived if the Covered Person is subsequently admitted to the hospital for an Inpatient Stay.]			
[[Emergency Room Copayment applies only to the Emergency Room charges.] [Once this amount is paid, We will pay the remaining Emergency Room charge at [100%].] [All other covered charges associated with the Emergency Room visit will be subject to the [Plan] [Integrated] [Per Cause] [and] [Inpatient Medical Facility Services] [Deductible] and [Plan] [and] [Inpatient Medical Facility Services] Coinsurance [unless otherwise specified.]]			
[Non-Emergency use of an Emergency Room will result in a [30%] reduction in Covered Charges]			
	[[Select] Participating Provider [Benefits]]	**[Participating Provider [Benefits] / Network Provider [Benefits]]**	**[Non-[Select] Participating Provider [Benefits]/ Non-Participating Provider [Benefits]/ Non-Network Provider [Benefits]]**
[[Outpatient [Services] Maximum Benefit]	$[XXX] [Per Covered Person]	$[XXX] [Per Covered Person]	$[XXX] [Per Covered Person]
[[Outpatient Services] Maximum Benefit] [due to an [Accidental Injury] [Injury] [or] [underlying Sickness]]	$[XXX] [Per Covered Person]	$[XXX] [Per Covered Person]	$[XXX] [Per Covered Person]
[[Outpatient [Surgical] [Services] [Per Cause] Deductible] [each [Calendar Year] [Benefit Period] [Time Period] [Plan Year] [Individual] [Integrated] [Family]	[$XXX / None] [$XXX / None]	[$XXX / None] [$XXX / None]	[$XXX / None] [$XXX / None]
[The [Outpatient [Surgical] Services] Deductible] does [not] apply to the [Plan] [Integrated] [Per Cause] Deductible] or Total [Plan] Out-of-Pocket Limits.]			
[[Non-Participating] [Non-Network] Provider Deductible is in addition to the [Participating] [Network] Provider Deductible.]			
[Once [[2] or more Covered Persons have collectively met] the maximum Family Deductible [has been met]], no additional Deductible will be taken during the [Calendar Year] [Plan Year] [Benefit Period] [Time Period].]			
[Facility] [Access] [Fee]	[None] [[$XXX] [per Outpatient Surgical Service]]	[None] [[$XXX] [per Outpatient Surgical Service]]	[None] [[$XXX] [per Outpatient Surgical Service]]
[Emergency Room [Access] [Fee]	[None] [[$XXX] [per Emergency Room Visit]]	[None] [[$XXX] [per Emergency Room Visit]]	[None] [[$XXX] [per Emergency Room Visit]]
[Facility] [Emergency Room] [Copayment]	[None] [[$XXX] [per Outpatient Surgical Service]]	[None] [[$XXX] [per Outpatient Surgical Service]]	[Subject to [Plan] [and] [Outpatient] [Integrated] [Per Cause] Deductible] and [Plan] [and] [Outpatient] Coinsurance [unless otherwise specified].]
[[Outpatient [Surgical] Services] [Coinsurance]] [Tier [1]]	[0% - 100% [until the [[Outpatient [Surgical] Services]] [Tier [1]] Out-of-Pocket Limits are satisfied; [then Tier [2];] [100% thereafter.]]	[0% - 100% [until the [[Outpatient [Surgical] Services] [Tier [1]] Out-of-Pocket Limits are satisfied; [then Tier [2];] [100% thereafter.]]	[0% - 100% [until the [[Outpatient [Surgical] Services] [Tier [1]] Out-of-Pocket Limits are satisfied; [then Tier [2];] [100% thereafter.]]

[Tier [1]] [[Outpatient [Surgical] Services] [Out-of-Pocket Limit] [each [Calendar Year] [Benefit Period] [Time Period] [Plan Year]] [Individual]	[$0 - $25,000 / Not applicable]	[$0 - $25,000 / Not applicable]	[$0 - $25,000 / an additional $0 - $10,000]
[Family]	[$0 - $75,000 / Not applicable]	[$0 - $75,000 / Not applicable]	[$0 - $75,000 / an additional $0 - $30,000]
[[Outpatient [Surgical] Services] [Coinsurance]] [Tier [2]]	[0% - 100% [until the [[Outpatient [Surgical] Services] [Tier [2]] Out-of-Pocket Limits are satisfied; [then Tier [X];] [100% thereafter.]]	[0% - 100% [until the [[Outpatient [Surgical] Services] [Tier [2]] Out-of-Pocket Limits are satisfied; [then Tier [X];] [100% thereafter.]]	[0% - 100% [until the [[Outpatient [Surgical] Services] [Tier [2]] Out-of-Pocket Limits are satisfied; [then Tier [X];] [100% thereafter.]]
[Tier [2]] [[Outpatient [Surgical] Services] [Out-of-Pocket Limit] [each [Calendar Year] [Benefit Period] [Time Period] [Plan Year]] [Individual]	[$0 - $25,000 / Not applicable]	[$0 - $25,000 / Not applicable]	[$0 - $25,000 / an additional $0 - $10,000]
[Family]	[$0 - $75,000 / Not applicable]	[$0 - $75,000 / Not applicable]	[$0 - $75,000 / an additional $0 - $30,000]
[[Outpatient [Surgical] Services] [Coinsurance]] [Tier [X]]	[0% - 100% [until the [[Outpatient [Surgical] Services] [Tier [X]] Out-of-Pocket Limits are satisfied;] [then Tier [X + [1]];] [100% thereafter.]]	[0% - 100% [until the [[Outpatient [Surgical] Services] [Tier [X]] Out-of-Pocket Limits are satisfied;] [then Tier [X + [1]];] [100% thereafter.]]	[0% - 100%[then Tier [X + [1]];] [until the [[Outpatient [Surgical] Services] [Tier [X]] Out-of-Pocket Limits are satisfied;] [then Tier [X + [1]];] [100% thereafter.]]
[Tier [X]] [[Outpatient [Surgical] Services] [Out-of-Pocket Limit] [each [Calendar Year] [Benefit Period] [Time Period] [Plan Year]] [Individual]	[$0 - $25,000 / Not applicable]	[$0 - $25,000 / Not applicable]	[$0 - $25,000 / an additional $0 - $10,000]
[Family]	[$0 - $75,000 / Not applicable]	[$0 - $75,000 / Not applicable]	[$0 - $75,000 / an additional $0 - $30,000]
[[Outpatient [Surgical] Services] Out-of-Pocket Limits] [each [Calendar Year] [Benefit Period] [Time Period] [Plan Year]] [Individual]	[$XXX]	[$XXX]	[$XXX]

[Family]	[$XXX]	[$XXX]	[$XXX]

BEN: 025.001.GE

[**Physician**][**Doctor**] [**Office Visit**]:
[All services, supplies and treatments apply to the [Outpatient] [and] [Calendar Year] [and] [Plan Year] [Benefit Period] [Per Cause] Maximum Benefit.]
[Subject to [Plan] [and] [Outpatient] [Integrated] [Per Cause] Deductible] and [Plan] [and] [Outpatient] Coinsurance [unless otherwise specified].]
[After [XX] [Primary Care Provider] Office Visit[s] [or] [Retail Health Clinic visit[s]] in a [Calendar Year] [Plan Year] [Benefit Period] [Per Cause] [month] [per] [Covered Person] [per covered child], Covered Charges will be subject to the [Plan [Per Cause] Deductible,] [and] [Outpatient Deductible,] [and] [Outpatient] [Coinsurance].]
[After application of the [Primary Care Provider] Copayment, Covered Charges for [Primary Care Provider] Office Visits [or] [Retail Health Clinic visits] will be subject to the [Plan],[and] [Outpatient] [Per Cause] Deductible,] [and] [Outpatient] [Coinsurance].]
[After [XX] [Designated Specialty Care Provider] Office Visit[s] [or] [Retail Health Clinic visit[s]] in a [Calendar Year] [Plan Year] [Benefit Period] [Per Cause] [month] [per] [Covered Person] [per covered child], Covered Charges will be subject to the [Plan [Per Cause] Deductible],] [Outpatient Deductible,] [and] [Outpatient] [Coinsurance].]
[After application of the [Designated Specialty Care Provider] Copayment, Covered Charges for [Designated Specialty Care Provider] Office Visits [or] [Retail Health Clinic visits] will be subject to the [Plan [Per Cause] Deductible],] [Outpatient Deductible,] [and] [Outpatient] [Coinsurance].]
[After [XX] [Mid-Level Practitioner] Office Visit[s] [or] [Retail Health Clinic visit[s]] in a [Calendar Year] [Plan Year] [Benefit Period] [Per Cause] [month] [per] [Covered Person] [per covered child], Covered Charges will be subject to the [Plan [Per Cause] Deductible],] [Outpatient Deductible,] [and] [Outpatient] [Coinsurance].]
[After application of the [Mid-Level Practitioner] Copayment, Covered Charge for [Mid-Level Practitioner] Office Visits [or] [Retail Health Clinic visits] will be subject to the [Plan [Per Cause] Deductible],] [Outpatient Deductible,] [and] [Outpatient] [Coinsurance].]
[After [XX] [Retail Health Clinic visit[s]] in a [Calendar Year] [Plan Year] [Benefit Period] [Per Cause] [month] [per] [Covered Person] [per covered child], Covered Charges will be subject to the [Plan [Per Cause] Deductible],] [Outpatient Deductible,] [and] [Outpatient] [Coinsurance].]
[After application of the [Retail Health Clinic visit[s]] Copayment, Covered Charges [for Retail Health Clinic visits] will be subject to the [Plan [Per Cause] Deductible],] [Outpatient Deductible,] [and] [Outpatient] [Coinsurance].]
[[Physician][Doctor] [Office Visit] [or] [Retail Health Clinic visit] Copayments will [not] apply toward any Out-of-Pocket Limits].]
[[Physician][Doctor] [Office Visit] [or] [Retail Health Clinic visit] [Copayment] Includes the first [$50 - $2~~1~~00] of a [Select Participating Provider] [Participating Provider] Diagnostic Imaging Services] [per Covered Person] [Per Covered Child] [per [Calendar Year] [Plan Year] [Benefit Period] [Per Cause].]
[Benefits for [Physician][Doctor] Office Visits [or] [Retail Health Clinic visits] are limited to [[2] visits each [Calendar Year] [Plan Year] [Benefit Period] [Per Cause] per Covered [Person][Child] with] a maximum payment of [$25 - $~~5~~100] per visit.] [After that, Office Visits [or] [Retail Health Clinic visits] are subject to the [Plan [Per Cause] Deductible],] [Outpatient Deductible,] [and] [Outpatient] [Coinsurance].]
[[Physician][Doctor] [Office Visits] [or] [Retail Health Clinic visits] [Copayment] Benefit Waiting Period is [[12] months] [[365] days].]

	[[Select] Participating Provider [Benefits]]	**[Participating Provider [Benefits] / Network Provider [Benefits]]**	**[Non-[Select] Participating Provider [Benefits]/ Non-Participating Provider [Benefits]/ Non-Network Provider [Benefits]]**
[Physician][Doctor] [Mid-Level Practitioner] [Office Visit] [Retail Health Clinic visit] Maximum [Lifetime] [Calendar Year] [Plan	[$XXX] [per Covered Person] [Per Covered Child]	[$XXX] [per Covered Person] [Per Covered Child]	[$XXX] [per Covered Person] [Per Covered Child]

Year] [Benefit Period] [Per Cause] [Monthly] [Daily] Benefit]			
[Physician][Doctor] [Mid-Level Practitioner] [Office Visit] [Retail Health Clinic visit] Maximum [Lifetime] [Calendar Year] [Plan Year] [Benefit Period] [Per Cause] [Monthly] [Daily] Benefit]	[$XXX] [per Covered Person] [Per Covered Child]	[$XXX] [per Covered Person] [Per Covered Child]	[$XXX] [per Covered Person] [Per Covered Child]
[Physician][Doctor] [Mid-Level Practitioner] [Office Visit Deductible] [Retail Health Clinic visit Deductible] [Individual] [Per Covered Child] [Integrated] [Family]	[$XXX] [$XXX]	[$XXX] [$XXX]	[$XXX] [$XXX]
[Physician][Doctor] [Mid-Level Practitioner] [Office Visit Deductible] [Retail Health Clinic visit Deductible] [Individual] [Per Covered Child] [Integrated] [Family]	[$XXX] [$XXX]	[$XXX] [$XXX]	[$XXX] [$XXX]
[The [Physician][Doctor] [Mid-Level Practitioner] [Office Visit Deductible] [Retail Health Clinic visit Deductible] does [not] apply to the Plan Deductible or Total Out-of-Pocket Limits.]			
[[Non-Participating] [Non-network] Provider Deductible is in addition to the [Participating] [Network] Provider Deductible.]			
[Once [[2] or more Covered Persons have collectively met] the maximum Family Deductible [has been met], no additional Deductible will be taken during the [Calendar Year] [Plan Year] [Benefit Period] [Time Period].]			
[Tiered] [Copayment:][After Copayment, [Participating] [Network] [Select] Office Visits [Retail Health Clinic visits] paid at 100%] [Primary Care Provider]	[None] [$5 - $65 per office visit] [for up to [X] visits] [per Calendar Year] [for the first [1-30] visits] [in the first [[Calendar] [Plan] [Year] [Benefit Period]] [and] [,] [$5-$65][for the next [1-30] visits] [in the second [[Calendar] [Plan] Year] [Benefit Period]] [and [$5-$65] [for the next [1-30] visits] [in the subsequent [[Calendar] [Plan] Years] [Benefit Period]] [per [Covered Person] [covered child]] [per [Calendar] [Plan]	[None] [$5 - $65 per office visit] [for up to [X] visits] [per Calendar Year] [for the first [1-30] visits] [in the first [[Calendar] [Plan] [Year] [Benefit Period]] [and] [,] [$5-$65][for the next [1-30] visits] [in the second [[Calendar] [Plan] Year] [Benefit Period]] [and [$5-$65] [for the next [1-30] visits] [in the subsequent [[Calendar] [Plan] Years] [Benefit Period]] [per [Covered Person] [covered child]] [per [Calendar] [Plan]	[Subject to [Designated Specialty Provider] [Plan] [Outpatient] [Integrated] [[Per Cause] [Deductible]] [and] [Outpatient] [Coinsurance]

	Year] [Additional Office Visits are][Additional Retail Health Clinic visits are][subject to [Designated Specialty Provider] [Plan] [Outpatient] [Integrated] [[Per Cause] [Deductible]] [and] [Outpatient] [Coinsurance]]	Year] [Additional Office Visits are] [Additional Retail Health Clinic visits are] [subject to [Designated Specialty Provider] [Plan] [Outpatient] [Integrated] [[Per Cause] [Deductible]] [and] [Outpatient] [Coinsurance]]	
[Designated Specialty Care Provider]	[None]~~/~~ [$5 - $65 per office visit] [for up to [X] visits] [per Calendar Year] [for the first [1-30] visits] [in the first [[Calendar] [Plan] [Year] [Benefit Period]] [and] [,] [$5-$65][for the next [1-30] visits] [in the second [[Calendar] [Plan] Year] [Benefit Period]] [and [$5-$65] [for the next [1-30] visits] [in the subsequent [[Calendar] [Plan] Years] [Benefit Period]] [per [Covered Person] [covered child]] [per [Calendar] [Plan] Year] [Additional Office Visits are] [Additional Retail Health Clinic visits are][subject to [Designated Specialty Provider] [Plan] [Outpatient] [Integrated] [[Per Cause [Deductible]] [and] [Outpatient] [Coinsurance]]	[None]~~/~~ [$5 - $65 per office visit] [for up to [X] visits] [per Calendar Year] [for the first [1-30] visits] [in the first [[Calendar] [Plan] [Year] [Benefit Period]] [and] [,] [$5-$65][for the next [1-30] visits] [in the second [[Calendar] [Plan] Year] [Benefit Period]] [and [$5-$65] [for the next [1-30] visits] [in the subsequent [[Calendar] [Plan] Years] [Benefit Period]] [per [Covered Person] [covered child]] [per [Calendar] [Plan] Year] [Additional Office Visits are] [Additional Retail Health Clinic visits are][subject to [Designated Specialty Provider] [Plan] [Outpatient] [Integrated] [[Per Cause] [Deductible]] [and] [Outpatient] [Coinsurance]]	[Subject to [Designated Specialty Provider] [Plan] [Outpatient] [Integrated] [[Per Cause] [Deductible] [and] [Outpatient] [Coinsurance]
[Mid-Level Practitioner]	[None]~~/~~ [$5 - $65 per office visit] [for up to [X] visits] [per Calendar Year] [for the first [1-30] visits] [in the first [[Calendar] [Plan] [Year] [Benefit Period]] [and] [,] [$5-$65][for the next [1-30] visits] [in the second [[Calendar] [Plan] Year] [Benefit Period]] [and [$5-$65]	[None]~~/~~ [$5 - $65 per office visit] [for up to [X] visits] [per Calendar Year] [for the first [1-30] visits] [in the first [[Calendar] [Plan] [Year] [Benefit Period]] [and] [,] [$5-$65][for the next [1-30] visits] [in the second [[Calendar] [Plan] Year] [Benefit Period]] [and [$5-$65]	[Subject to [Designated Specialty Provider] [Plan] [Outpatient] [Integrated] [[Per Cause] [Deductible]] [and] [Outpatient] [Coinsurance]

[Retail Health Clinic]	[for the next [1-30] visits] [in the subsequent [[Calendar] [Plan] Years] [Benefit Period]] [per [Covered Person] [covered child]] [per [Calendar] [Plan] Year] [Additional Office Visits are] [Additional Retail Health Clinic visits are][subject to [Designated Specialty Provider] [Plan] [Outpatient] [Integrated] [[Per Cause] [Deductible]] [and] [Outpatient] [Coinsurance]] [None] [$5 - $65 per office visit] [for up to [X] visits] [per Calendar Year] [for the first [1-30] visits] [in the first [[Calendar] [Plan] [Year] [Benefit Period]] [and] [,] [$5-$65] [for the next [1-30] visits] [in the second [[Calendar] [Plan] Year] [Benefit Period]] [and [$5-$65] [for the next [1-30] visits] [in the subsequent [[Calendar] [Plan] Years] [Benefit Period]] [per [Covered Person] [covered child]] [per [Calendar] [Plan] Year] [Additional Office Visits are] [Additional Retail Health Clinic visits are][subject to [Designated Specialty Provider] [Plan] [Outpatient] [Integrated] [[Per Cause] [Deductible]] [and] [Outpatient] [Coinsurance]]	[for the next [1-30] visits] [in the subsequent [[Calendar] [Plan] Years] [Benefit Period]] [per [Covered Person] [covered child]] [per [Calendar] [Plan] Year] [Additional Office Visits are] [Additional Retail Health Clinic visits are][subject to [Designated Specialty Provider] [Integrated] [Plan] [Outpatient] [[Per Cause] [Deductible]] [and] [Outpatient] [Coinsurance]] [None] [$5 - $65 per office visit] [for up to [X] visits] [per Calendar Year] [for the first [1-30] visits] [in the first [[Calendar] [Plan] [Year] [Benefit Period]] [and] [,] [$5-$65] [for the next [1-30] visits] [in the second [[Calendar] [Plan] Year] [Benefit Period]] [and [$5-$65] [for the next [1-30] visits] [in the subsequent [[Calendar] [Plan] Years] [Benefit Period]] [per [Covered Person] [covered child]] [per [Calendar] [Plan] Year] [Additional Office Visits are] [Additional Retail Health Clinic visits are] [subject to [Designated Specialty Provider] [Integrated] [Plan] [Outpatient] [[Per Cause] [Deductible]] [and] [Outpatient] [Coinsurance]]	[Subject to [Designated Specialty Provider] [Plan] [Outpatient] [Integrated] [[Per Cause] [Deductible]] [and] [Outpatient] [Coinsurance]
[Tiered] [Copayment:][After Copayment, [Participating] [Network] [Select] Office Visits [Retail Health Clinic visit] paid at 100%]			

Primary Care Provider]	[None] [$5 - $65 per office visit] [for up to [X] visits] [per Calendar Year] [for the first [1-30] visits] [in the first [[Calendar] [Plan] [Year] [Benefit Period]] [and] [,] [$5-$65][for the next [1-30] visits] [in the second [[Calendar] [Plan] Year] [Benefit Period]] [and [$5-$65] [for the next [1-30] visits] [in the subsequent [[Calendar] [Plan] Years] [Benefit Period]] [per [Covered Person] [covered child]] [per [Calendar] [Plan] Year] [Additional Office Visits are] [Additional Retail Health Clinic visits are][subject to [Designated Specialty Provider] [Plan] [Outpatient] [Integrated] [[Per Cause] [Deductible]] [and] [Outpatient] [Outpatient] [Coinsurance]]	[None] [$5 - $65 per office visit] [for up to [X] visits] [per Calendar Year] [for the first [1-30] visits] [in the first [[Calendar] [Plan] [Year] [Benefit Period]] [and] [,] [$5-$65][for the next [1-30] visits] [in the second [[Calendar] [Plan] Year] [Benefit Period]] [and [$5-$65] [for the next [1-30] visits] [in the subsequent [[Calendar] [Plan] Years] [Benefit Period]] [per [Covered Person] [covered child]] [per [Calendar] [Plan] Year] [Additional Office Visits are] [Additional Retail Health Clinic visits are][subject to [Designated Specialty Provider] [Plan] [Outpatient] [Integrated] [[Per Cause] [Deductible]] [and] [Outpatient] [Outpatient] [Coinsurance]]	[Subject to [Designated Specialty Provider] [Plan] [Outpatient] [Integrated] [[Per Cause] [Deductible]] [and] [Outpatient] [Coinsurance]
[Designated Specialty Care Provider]	[None]/ [$5 - $65 per office visit] [for up to [X] visits] [per Calendar Year] [for the first [1-30] visits] [in the first [[Calendar] [Plan] [Year] [Benefit Period]] [and] [,] [$5-$65][for the next [1-30] visits] [in the second [[Calendar] [Plan] Year] [Benefit Period]] [and [$5-$65] [for the next [1-30] visits] [in the subsequent [[Calendar] [Plan] Years] [Benefit Period]] [per [Covered Person] [covered child]] [per [Calendar] [Plan] Year] [Additional Office Visits are] [Additional Retail Health Clinic visits are][subject to [Designated Specialty	[None]/ [$5 - $65 per office visit] [for up to [X] visits] [per Calendar Year] [for the first [1-30] visits] [in the first [[Calendar] [Plan] [Year] [Benefit Period]] [and] [,] [$5-$65][for the next [1-30] visits] [in the second [[Calendar] [Plan] Year] [Benefit Period]] [and [$5-$65] [for the next [1-30] visits] [in the subsequent [[Calendar] [Plan] Years] [Benefit Period]] [per [Covered Person] [covered child]] [per [Calendar] [Plan] Year] [Additional Office Visits are] [Additional Retail Health Clinic visits are][subject to [Designated Specialty	[Subject to [Designated Specialty Provider] [Plan] [Outpatient] [Integrated] [[Per Cause] [Deductible] [and] [Coinsurance]

	Provider] [Plan] [Outpatient] [Integrated] [[Per Cause [Deductible]] [and] [Outpatient] [Coinsurance]]	Provider] [Plan] [Outpatient] [Integrated] [[Per Cause] [Deductible]] [and] [Outpatient] [Coinsurance]]	
[Mid-Level Practitioner]	[None]~~/~~ [$5 - $65 per office visit] [for up to [X] visits] [per Calendar Year] [for the first [1-30] visits] [in the first [[Calendar] [Plan] [Year] [Benefit Period]] [and] [,] [$5-$65][for the next [1-30] visits] [in the second [[Calendar] [Plan] Year] [Benefit Period]] [and [$5-$65] [for the next [1-30] visits] [in the subsequent [[Calendar] [Plan] Years] [Benefit Period]] [per [Covered Person] [covered child]] [per [Calendar] [Plan] Year] [Additional Office Visits are] [Additional Retail Health Clinic visits are][subject to [Designated Specialty Provider] [Plan] [Outpatient] [Integrated] [[Per Cause] [Deductible]] [and] [Outpatient] [Coinsurance]]	[None]~~/~~ [$5 - $65 per office visit] [for up to [X] visits] [per Calendar Year] [for the first [1-30] visits] [in the first [[Calendar] [Plan] [Year] [Benefit Period]] [and] [,] [$5-$65][for the next [1-30] visits] [in the second [[Calendar] [Plan] Year] [Benefit Period]] [and [$5-$65] [for the next [1-30] visits] [in the subsequent [[Calendar] [Plan] Years] [Benefit Period]] [per [Covered Person] [covered child]] [per [Calendar] [Plan] Year] [Additional Office Visits are] [Additional Retail Health Clinic visits are][subject to [Designated Specialty Provider] [Integrated] [Plan] [Outpatient] [[Per Cause] [Deductible]] [and] [Outpatient] [Coinsurance]]	[Subject to [Designated Specialty Provider] [Plan] [Outpatient] [Integrated] [[Per Cause] [Deductible]] [and] [Outpatient] [Coinsurance]
[Retail Health Clinic]	[None] [$5 - $65 per office visit] [for up to [X] visits] [per Calendar Year] [for the first [1-30] visits] [in the first [[Calendar] [Plan] [Year] [Benefit Period]] [and] [,] [$5-$65] [for the next [1-30] visits] [in the second [[Calendar] [Plan] Year] [Benefit Period]] [and [$5-$65] [for the next [1-30] visits] [in the subsequent [[Calendar] [Plan] Years] [Benefit Period]] [per [Covered	[None] [$5 - $65 per office visit] [for up to [X] visits] [per Calendar Year] [for the first [1-30] visits] [in the first [[Calendar] [Plan] [Year] [Benefit Period]] [and] [,] [$5-$65] [for the next [1-30] visits] [in the second [[Calendar] [Plan] Year] [Benefit Period]] [and [$5-$65] [for the next [1-30] visits] [in the subsequent [[Calendar] [Plan] Years] [Benefit Period]] [per [Covered	[Subject to [Designated Specialty Provider] [Plan] [Outpatient] [Integrated] [[Per Cause] [Deductible]] [and] [Outpatient] [Coinsurance]

	Person] [covered child]] [per [Calendar] [Plan] Year] [Additional Office Visits are] [Additional Retail Health Clinic visits are][subject to [Designated Specialty Provider] [Plan] [Outpatient] [Integrated] [[Per Cause] [Deductible]] [and] [Outpatient] [Coinsurance]]	Person] [covered child]] [per [Calendar] [Plan] Year] [Additional Office Visits are] [Additional Retail Health Clinic visits are][subject to [Designated Specialty Provider] [Integrated] [Plan] [Outpatient] [[Per Cause] [Deductible]] [and] [Outpatient] [Coinsurance]]	
[Physician][Doctor] [Office Visit] [Retail Health Clinic visit] [Coinsurance] [Tier [1]]	[0% - 100% [until the [Office Visit] [Retail Health Clinic visit] [Tier [1]] Out-of-Pocket Limits are satisfied; [then Tier [2];] [100% thereafter.]]	[0% - 100% [until the [Office Visit] [Retail Health Clinic visit] [Tier [1]] Out-of-Pocket Limits are satisfied; [then Tier [2];] [100% thereafter.]]	[0% - 100% [until the [Office Visit] [Retail Health Clinic visit] [Tier [1]] Out-of-Pocket Limits are satisfied; [then Tier [2];] [100% thereafter.]]
[Tier [1]] [Physician][Doctor] [Office Visit] [Retail Health Clinic visit] [Out-of-Pocket Limit][each [Calendar Year] [Benefit Period] [Time Period] [Plan Year]] [Individual] [Per Covered Child] [Family]	[$0 - $25,000 / Not applicable] [$0 - $75,000 / Not applicable]	[$0 - $25,000 / Not applicable] [$0 - $75,000 / Not applicable]	[$0 - $25,000 / an additional $0 - $10,000] [$0 - $75,000 / an additional $0 - $30,000]
[Physician][Doctor] [Office Visit] [Retail Health Clinic visit] [Coinsurance] [Tier [2]]	[0% - 100% [until the [Office Visit] [Retail Health Clinic visit] [Tier [2]] Out-of-Pocket Limits are satisfied; [then Tier [X];] [100% thereafter.]]	[0% - 100% [until the] [Office Visit] [Retail Health Clinic visit] ~~[Patient Medical Facility]~~ [Tier [2]] Out-of-Pocket Limits are satisfied; [then Tier [X];] [100% thereafter.]]	[0% - 100% [until the [Office Visit] [Retail Health Clinic visit] [Tier [2]] Out-of-Pocket Limits are satisfied; [then Tier [X];] [100% thereafter.]]
[Tier [2]] [Physician][Doctor] [Office Visit] [Retail Health Clinic visit] Out-of-Pocket Limit [each [Calendar Year] [Benefit Period] [Time Period] [Plan Year]] [Individual] [Per Covered Child] [Family]	[$0 - $25,000 / Not applicable] [$0 - $75,000 / Not applicable]	[$0 - $25,000 / Not applicable] [$0 - $75,000 / Not applicable]	[$0 - $25,000 / an additional $0 - $10,000] [$0 - $75,000 / an additional $0 - $30,000]

[Physician][Doctor] [Office Visit] [Retail Health Clinic visit] [Coinsurance] [Tier [X]]	[0% - 100% [until the [Office Visit] [Retail Health Clinic visit] [Tier [X]] Out-of-Pocket Limits are satisfied;] [then Tier [X + [1]];] [100% thereafter.]]	[0% - 100% [until the [Office Visit] [Retail Health Clinic visit] [Tier [X]] Out-of-Pocket Limits are satisfied;] [then Tier [X + [1]];] [100% thereafter.]]	[0% - 100% [until the [Office Visit] [Retail Health Clinic visit] [Tier [X]] Out-of-Pocket Limits are satisfied;] [then Tier [X + [1]];] [100% thereafter.]]
[Tier [X]] [Physician][Doctor] [Office Visit] [Retail Health Clinic visit] Out-of-Pocket Limit [each [Calendar Year] [Benefit Period] [Time Period] [Plan Year]] [Individual] [Per Covered Child] [Family]	[$0 - $25,000 / Not applicable] [$0 - $75,000 / Not applicable]	[$0 - $25,000 / Not applicable] [$0 - $75,000 / Not applicable]	[$0 - $25,000 / an additional $0 - $10,000] [$0 - $75,000 / an additional $0 - $30,000]
[[Physician][Doctor] [Office Visit] [Retail Health Clinic visit] Out-of-Pocket Limits] [Individual] [Per Covered Child] [Family]	[$XXX] [$XXX]	[$XXX] [$XXX]	[$XXX] [$XXX]

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[Retail Health Clinic Visit:]
[All services, supplies and treatments apply to the [Outpatient] [and] [Calendar Year] [and] [Plan Year] [Benefit Period] [Per Cause] Maximum Benefit.]
[Subject to [Plan] [and] [Outpatient] [Integrated] [Per Cause] Deductible] and [Plan] [and] [Outpatient] Coinsurance [unless otherwise specified].]
[After [XX] [Retail Health Clinic visit[s]] in a [Calendar Year] [Plan Year] [Benefit Period] [Per Cause] [month] [per] [Covered Person] [per covered child], Covered Charges will be subject to the [Plan [Per Cause] Deductible,] [and] [Outpatient Deductible,] [and] [Outpatient] [Coinsurance].]
[After application of the [Retail Health Clinic visit] Copayment, Covered Charges for [Retail Health Clinic visits] will be subject to the [Plan][,] [and] [Outpatient] [Per Cause] Deductible,] [and] [Outpatient] [Coinsurance].]
[[Retail Health Clinic visit] Copayments will [not] apply toward any Out-of-Pocket Limits]
[[Retail Health Clinic visit] [Copayment] includes the first [$50 - $2,100] of a [Select Participating Provider] [Participating Provider] Diagnostic Imaging Services] [per Covered Person] [Per Covered Child] [per [Calendar Year] [Plan Year] [Benefit Period] [Per Cause]]
[Benefits for [Retail Health Clinic visits] are limited to [[XX] visits each [Calendar Year] [Plan Year] [Benefit Period] [Per Cause] per Covered [Person][Child] with] a maximum payment of [$25 - $5,100] per visit.] [After that, Retail Health Clinic visits are subject to the [Plan [Per Cause] Deductible],] [Outpatient Deductible,] [and] [Outpatient] [Coinsurance]].
[[Plan] [Integrated] [Per Cause] Deductible] [and Coinsurance] will be waived for the first [$XXX] [XX visits] of Covered Services performed [by a [Retail Health Clinic] [per] [Covered Person] [covered child] [Family] [per [Calendar Year] [Plan Year] [Benefit Period] [Per Cause] [after a [12 month] [365 day] Benefit Waiting Period] [subject to a [$XX] copayment].]
[[Retail Health Clinic visits] [Copayment] Benefit Waiting Period is [[12] months] [[365] days].]

	[[Select] Participating	**[Participating Provider**	**[Non-[Select]**

	Provider [Benefits]]	[Benefits] / Network Provider [Benefits]]	Participating Provider [Benefits]/ Non-Participating Provider [Benefits]/ Non-Network Provider [Benefits]]
[Retail Health Clinic visit] Maximum [Lifetime] [Calendar Year] [Plan Year] [Benefit Period] [Per Cause] [Monthly] [Daily] Benefit]	[$XXX] [per Covered Person] [Per Covered Child]	[$XXX] [per Covered Person] [Per Covered Child]	[$XXX] [per Covered Person] [Per Covered Child]
[Retail Health Clinic visit Deductible] [Individual] [Per Covered Child]	[$XXX]	[$XXX]	[$XXX]
[Integrated] [Family]	[$XXX]	[$XXX]	[$XXX]
[The [Retail Health Clinic visit Deductible] does [not] apply to the Plan Deductible or Total Out-of-Pocket Limits.]			
[[Non-Participating] [Non-network] Provider Deductible is in addition to the [Participating] [Network] Provider Deductible.]			
[Once [[2] or more Covered Persons have collectively met] the maximum Family Deductible [has been met], no additional Deductible will be taken during the [Calendar Year] [Plan Year] [Benefit Period] [Time Period].]			
[Copayment:][After Copayment, Retail Health Clinic visits paid at 100%]	[None] [$5 - $65 per Retail Health Clinic visit] [for up to [X] visits] [per Calendar Year] [per [Covered Person] [covered child]] [per [Calendar] [Plan] Year]	[None] [$5 - $65 per Retail Health Clinic visit] [for up to [X] visits] [per Calendar Year] [per [Covered Person] [covered child]] [per [Calendar] [Plan] Year]	[Subject to [Plan] [Outpatient] [Integrated] [[Per Cause] [Deductible]] [and] [Outpatient] [Coinsurance]

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[**Preventive Medicine Services**:]
[All services, supplies and treatments apply to the [Outpatient] [and] [Calendar Year] [and] [Plan Year] [and] [Benefit Period] [Per Cause] Maximum Benefit]
[Subject to [Plan] [and] [Outpatient] [Integrated] [Per Cause] Deductible] and [Plan] [and] [Outpatient] Coinsurance [unless otherwise specified]]
[[Plan] [Integrated] [Per Cause] Deductible] [and Coinsurance] will be waived for the first [$XXX] of Covered Services performed [by a [Participating Provider] [Network Provider] [Retail Health Clinic]] [per] [Covered Person] [covered child] [Family] [per [Calendar Year] [Plan Year] [Benefit Period] [Per Cause] [after a [12 month] Benefit Waiting Period][subject to a [$XX] copayment] [for Mammograms] [and] [, Pap Smears] [and] [Prostate Specific Antigen Screenings] [and] [Stool for occult blood testing] [and] [Flexible sigmoidoscopy and barium enema [for colonoscopy]] [and] Fasting glucose testing] [and] [Lipid profile testing] [and] [Complete blood count (or component parts) testing] [and] [Urinalysis testing] [and] [Tuberculin skin testing with purified protein derivative] [and] [Other diagnostic services as recommended by the United States Preventative Services Task Force on the date the service is Incurred].]
[Benefits for Preventive Medicine Services are limited [to a [$XX] per visit] [up to [XX] visits per] [Calendar Year] [Plan Year] [Monthly] [Daily] [Benefit Period] [Per Cause] [per] [Covered Person] [covered child] [Family].]
[Benefit for Preventive Medicine Services are limited to a Maximum [Lifetime] [Calendar Year] [Plan Year] [Monthly] [Daily] [Benefit Period] [Benefit] of [$XXX] [per [Covered Person] [covered child] [Family].]
[Benefits for Preventive Medicine Services are limited to a Maximum [Lifetime] [Benefit] of [$XXX] [per [Covered Person] [covered child] [Family].]
[Benefits for Preventive Medicine Services are limited to a Maximum Benefit of [[$XX] for each visit] [or] [up to [$XXX] each [Calendar] [Plan] [Benefit] Year] [per [Covered Person] [covered child] [Family].]

[[Mammograms] [Pap Smears] [and] [Prostate Specific Antigen Screenings] Colorectal Cancer Examination [and] [child immunizations up to age [12]] are not subject to the [Preventive Services] [Calendar Year] [Plan Year] [Benefit Period] [Per Cause] Maximum [Lifetime] Benefit]			
[Preventive Medicine Services Benefit Waiting Period is [12] [months] [[365] days].]			
[Not Covered]			
	[[Select] Participating Provider [Benefits]]	**[Participating Provider [Benefits] / Network Provider [Benefits]]**	**[Non-[Select] Participating Provider [Benefits]/ Non-Participating Provider [Benefits]/ Non-Network Provider [Benefits]]**
[[Preventive Medicine Services] Maximum [Lifetime] [Calendar Year] [Plan Year] [Benefit Period] [Per Cause] [Monthly] [Daily] Benefit]	[$XXX] [per Covered Person] [Per Covered Child]	[$XXX] [per Covered Person] [Per Covered Child]	[$XXX] [per Covered Person] [Per Covered Child]
[Preventive Medicine Services Deductible] [Individual] [Per Covered Child] [Integrated] [Family]	[$XXX] [$XXX]	[$XXX] [$XXX]	[$XXX] [$XXX]
[The [Preventive Medicine Services Deductible] does [not] apply to the Plan Deductible or Total Out-of-Pocket Limits.]			
[[Non-Participating] [Non-Network] [Retail Health Clinic] Provider Deductible is in addition to the [Participating] [Network] [Retail Health Clinic] Provider Deductible.]			
[Once [[2] or more Covered Persons have collectively met] the maximum Family Deductible [has been met], no additional Deductible will be taken during the [Calendar Year] [Plan Year] [Benefit Period] [Time Period].]			
[Preventive Medicine Services] [Coinsurance] [Tier [1]]	[0% - 100% [until the [Preventive Medicine Services] [Tier [1]] Out-of-Pocket Limits are satisfied; [then Tier [2];] [100% thereafter.]]	[0% - 100% [until the [Preventive Medicine Services] [Tier [1]] Out-of-Pocket Limits are satisfied; [then Tier [2];] [100% thereafter.]]	[0% - 100% [until the [Preventive Medicine Services] [Tier [1]] Out-of-Pocket Limits are satisfied; [then Tier [2];] [100% thereafter.]]
[Tier [1]] [Preventive Medicine Services] [Out-of-Pocket Limit] [each [Calendar Year] [Benefit Period] [Time Period] [Plan Year]] [Individual] [Per Covered Child] [Family]	[$0 - $25,000 / Not applicable] [$0 - $75,000 / Not applicable]	[$0 - $25,000 / Not applicable] [$0 - $75,000 / Not applicable]	[$0 - $25,000 / an additional $0 - $10,000] [$0 - $75,000 / an additional $0 - $30,000]
[Preventive Medicine Services] [Coinsurance] [Tier [2]]	[0% - 100% [until the [Preventive Medicine Services] [Tier [2]] Out-of-Pocket Limits are satisfied; [then Tier [X];] [100% thereafter.]]	[0% - 100% [until the [Preventive Medicine Services] [Tier [2]] Out-of-Pocket Limits are satisfied; [then Tier [X];] [100% thereafter.]]	[0% - 100% [until the [I Preventive Medicine Services] [Tier [2]] Out-of-Pocket Limits are satisfied; [then Tier [X];] [100% thereafter.]]

[Tier [2]] [Preventive Medicine Services] [Out-of-Pocket Limit] [each [Calendar Year] [Benefit Period] [Time Period] [Plan Year]] [Individual] [Per Covered Child]	[$0 - $25,000 / Not applicable]	[$0 - $25,000 / Not applicable]	[$0 - $25,000 / an additional $0 - $10,000]
[Family]	[$0 - $75,000 / Not applicable]	[$0 - $75,000 / Not applicable]	[$0 - $75,000 / an additional $0 - $30,000]
[Preventive Medicine Services] [Coinsurance] [Tier [X]]	[0% - 100% [until the [Preventive Medicine Services] [Tier [X]] Out-of-Pocket Limits are satisfied;] [then Tier [X + [1]];] [100% thereafter.]]	[0% - 100% [until the [Preventive Medicine Services] [Tier [X]] Out-of-Pocket Limits are satisfied;] [then Tier [X + [1]];] [100% thereafter.]]	[0% - 100% [until the [Preventive Medicine Services] [Tier [X]] Out-of-Pocket Limits are satisfied;] [then Tier [X + [1]];] [100% thereafter.]]
[Tier [X]] [Preventive Medicine Services] [Out-of-Pocket Limit][each [Calendar Year] [Benefit Period] [Time Period] [Plan Year]] [Individual] [Per Covered Child]	[$0 - $25,000 / Not applicable]	[$0 - $25,000 / Not applicable]	[$0 - $25,000 / an additional $0 - $10,000]
[Family]	[$0 - $75,000 / Not applicable]	[$0 - $75,000 / Not applicable]	[$0 - $75,000 / an additional $0 - $30,000]
[[Preventive Medicine Services] Out-of-Pocket Limits] [Individual] [Per Covered Child]	[$XXX]	[$XXX]	[$XXX]
[Family]	[$XXX]	[$XXX]	[$XXX]
[Benefits for Preventive Medicine Services are payable at [0-100%] [with a [$10-$100] Copayment] when a Designated Specialty Service Provider is used. If a Designated Specialty Service Provider is not used, [Covered Charges will be [paid at the [Non-][Participating] [or] [applicable] Coinsurance] [reduced by [$1 - $3,000] [1% - 50%]][limited to [$XXX] per [Calendar] [Plan] Year] [per Covered Person] [after the Covered Person has paid any applicable Copayment, Deductible or other fees.] [These limitations will apply to all treatment rendered by a provider that is not designated as a [Designated Specialty Service Provider] regardless of whether the provider is a [Network Provider,] [Participating Provider,] [or] [Select Participating Provider].]~~of whether the provider is a [Network Provider,] [Participating Provider,] [or] [Select Participating Provider~~			

BEN: 035.001.001.GE

~~[Colorectal Cancer Examination Coverage]:~~			
~~[All services, supplies and treatments apply to the [Outpatient] [and] [Calendar Year] [and] [Plan Year] [and] [Benefit Period] [Per Cause] Maximum Benefit]~~			
~~[Subject to [Plan] [and] [Outpatient] [Integrated] [Per Cause] Deductible] and [Plan] [and] [Outpatient] Coinsurance [unless otherwise specified]]~~			
	~~[Select Participating Provider Benefits]~~	~~[Participating Provider Benefits / Network Provider~~	~~[Non-[Select] Participating Provider Benefits/ Non-~~

		Benefits]	Participating Provider Benefits/ Non-Network Provider Benefits]
[Colorectal Cancer Examination Coverage Deductible] [Individual] [Per Covered Child] [Integrated] [Family]	[$XXX] [$XXX]	[$XXX] [$XXX]	[$XXX] [$XXX]
[[Non-Participating] [Non-Network] Provider Deductible is in addition to the [Participating] [Network] Provider Deductible.]			
[Once [[2] or more Covered Persons have collectively met] the maximum Family Deductible [has been met], no additional Deductible will be taken during the [Calendar Year] [Plan Year] [Benefit Period] [Time Period].]			
[Colorectal Cancer Examination Coverage] [Coinsurance] [Tier [1]]	[0% - 100% [until the [Colorectal Cancer Examination Coverage] [Tier [1]] Out-of-Pocket Limits are satisfied; [then Tier [2];] [100% thereafter.]]	[0% - 100% [until the [Colorectal Cancer Examination Coverage] [Tier [1]] Out-of-Pocket Limits are satisfied; [then Tier [2];] [100% thereafter.]]	[0% - 100% [until the [Colorectal Cancer Examination Coverage] [Tier [1]] Out-of-Pocket Limits are satisfied; [then Tier [2];] [100% thereafter.]]
[Tier [1]] [Colorectal Cancer Examination Coverage] [Out-of-Pocket Limit] [each [Calendar Year] [Benefit Period] [Time Period] [Plan Year]] [Individual] [Per Covered Child] [Family]	[$0 - $25,000 / Not applicable] [$0 - $75,000 / Not applicable]	[$0 - $25,000 / Not applicable] [$0 - $75,000 / Not applicable]	[$0 - $25,000 / an additional $0 - $10,000] [$0 - $75,000 / an additional $0 - $30,000]
[Colorectal Cancer Examination Coverage] [Coinsurance] [Tier [2]]	[0% - 100% [until the [Colorectal Cancer Examination Coverage] [Tier [2]] Out-of-Pocket Limits are satisfied; [then Tier [X];] [100% thereafter.]]	[0% - 100% [until the [Colorectal Cancer Examination Coverage] [Tier [2]] Out-of-Pocket Limits are satisfied; [then Tier [X];] [100% thereafter.]]	[0% - 100% [until the [I Colorectal Cancer Examination Coverage] [Tier [2]] Out-of-Pocket Limits are satisfied; [then Tier [X];] [100% thereafter.]]
[Tier [2]] [Colorectal Cancer Examination Coverage] [Out-of-Pocket Limit] [each [Calendar Year] [Benefit Period] [Time Period] [Plan Year]] [Individual] [Per Covered Child] [Family]	[$0 - $25,000 / Not applicable] [$0 - $75,000 / Not applicable]	[$0 - $25,000 / Not applicable] [$0 - $75,000 / Not applicable]	[$0 - $25,000 / an additional $0 - $10,000] [$0 - $75,000 / an additional $0 - $30,000]

[Colorectal Cancer Examination Coverage] [Coinsurance] [Tier [X]]	[0% - 100% [until the [Colorectal Cancer Examination Coverage] [Tier [X]] Out of Pocket Limits are satisfied;] [then Tier [X + [1]];] [100% thereafter.]]	[0% - 100% [until the [Colorectal Cancer Examination Coverage] [Tier [X]] Out of Pocket Limits are satisfied;] [then Tier [X + [1]];] [100% thereafter.]]	[0% - 100% [until the [Colorectal Cancer Examination Coverage] [Tier [X]] Out of Pocket Limits are satisfied;] [then Tier [X + [1]];] [100% thereafter.]]
[Tier [X]] [Colorectal Cancer Examination Coverage] [Out-of-Pocket Limit][each [Calendar Year] [Benefit Period] [Time Period] [Plan Year]] [Individual] [Per Covered Child]	[$0 - $25,000 / Not applicable]	[$0 - $25,000 / Not applicable]	[$0 - $25,000 / an additional $0 - $10,000]
[Family]	[$0 - $75,000 / Not applicable]	[$0 - $75,000 / Not applicable]	[$0 - $75,000 / an additional $0 - $30,000]
[[P Colorectal Cancer Examination Coverage] Out-of-Pocket Limits] [Individual] [Per Covered Child]	[$XXX]	[$XXX]	[$XXX]
[Family]	[$XXX]	[$XXX]	[$XXX]
[Benefits for Colorectal Cancer Examination Coverage are payable at [0-100%] [with a [$10-$100] Copayment] when a Designated Specialty Service Provider is used. If a Designated Specialty Service Provider is not used, [Covered Charges will be [paid at the [Non-][Participating] [or] [applicable] Coinsurance] [reduced by [$1 - $3,000] [1% - 50%]][limited to [$XXX] per [Calendar] [Plan] Year] [per Covered Person] [after the Covered Person has paid any applicable Copayment, Deductible or other fees.] [These limitations will apply to all treatment rendered by a provider that is not designated as a [Designated Specialty Service Provider] regardless of whether the provider is a [Network Provider,] [Participating Provider,] [or] [Select Participating Provider].]of whether the provider is a [Network Provider,] [Participating Provider,] [or] [Select Participating Provider			

Children's Preventive Health Care Services
Preventive Medicine Services shall include children's preventive health care services which shall include 20 visits at approximately the following ages: birth, 2 weeks, 2 months, 4 months, 6 months, 9 months, 12 months, 15 months, 18 months, 2 years, 3 years, 4 years, 5 years, 6 years, 8 years, 10 years, 12 years, 14 years, 16 years, and 18 years.
[Subject to [Plan] [and] [Outpatient] [Integrated] [Per Cause] Deductible] and [Plan] [and] [Outpatient] Coinsurance [unless otherwise specified]] Deductible and Coinsurance will be waived for child immunizations.
[Benefit for Preventive Medicine Services are limited to a Maximum [Lifetime] [Calendar Year] [Plan Year] [Monthly] [Daily] [Benefit Period] [Benefit] of [$500] [per [Covered Person] [covered child] [Family].] The maximum will not apply to child immunizations.
[Preventive Medicine Services Benefit Waiting Period is [12] [months].] The waiting period will not apply to child immunizations.

BEN: 036.001.AR

[**Loss or Impairment of Speech or Hearing**]:
[All services, supplies and treatments apply to the [Outpatient] [and] [Calendar Year] [and] [Plan Year] [and] [Benefit Period] [Per Cause] Maximum Benefit]
[Subject to [Plan] [and] [Outpatient] [Integrated] [Per Cause] Deductible] and [Plan] [and] [Outpatient] Coinsurance [unless otherwise specified]]

	[Select] Participating	**[Participating**	**[Non-[Select]**

	Provider Benefits]	Provider Benefits / Network Provider Benefits]	Participating Provider Benefits/ Non-Participating Provider Benefits/ Non-Network Provider Benefits]
[[Loss or Impairment of Speech or Hearing] Maximum [Lifetime] [Calendar Year] [Plan Year] [Benefit Period] [Per Cause] [Monthly] [Daily] Benefit]	[$XXX] [per Covered Person] [Per Covered Child]	[$XXX] [per Covered Person] [Per Covered Child]	[$XXX] [per Covered Person] [Per Covered Child]
[Loss or Impairment of Speech or Hearing] Deductible] [Individual] [Per Covered Child] [Integrated] [Family]	[$XXX] [$XXX]	[$XXX] [$XXX]	[$XXX] [$XXX]
[[Non-Participating] [Non-Network] Provider Deductible is in addition to the [Participating] [Network] Provider Deductible.]			
[Once [[2] or more Covered Persons have collectively met] the maximum Family Deductible [has been met], no additional Deductible will be taken during the [Calendar Year] [Plan Year] [Benefit Period] [Time Period].]			
[Loss or Impairment of Speech or Hearing] [Coinsurance] [Tier [1]]	[0% - 100% [until the [Loss or Impairment of Speech or Hearing]] [Tier [1]] Out-of-Pocket Limits are satisfied; [then Tier [2];] [100% thereafter.]]	[0% - 100% [until the [Loss or Impairment of Speech or Hearing]] [Tier [1]] Out-of-Pocket Limits are satisfied; [then Tier [2];] [100% thereafter.]]	[0% - 100% [until the [Loss or Impairment of Speech or Hearing] [Tier [1]] Out-of-Pocket Limits are satisfied; [then Tier [2];] [100% thereafter.]]
[Tier [1]] [Loss or Impairment of Speech or Hearing] [Out-of-Pocket Limit] [each [Calendar Year] [Benefit Period] [Time Period] [Plan Year]] [Individual] [Per Covered Child] [Family]	[$0 - $25,000 / Not applicable] [$0 - $75,000 / Not applicable]	[$0 - $25,000 / Not applicable] [$0 - $75,000 / Not applicable]	[$0 - $25,000 / an additional $0 - $10,000] [$0 - $75,000 / an additional $0 - $30,000]
Loss or Impairment of Speech or Hearing] [Tier [2]]	[0% - 100% [until the [Loss or Impairment of Speech or Hearing] [Tier [2]] Out-of-Pocket Limits are satisfied; [then Tier [X];] [100% thereafter.]]	[0% - 100% [until the [Loss or Impairment of Speech or Hearing] [Tier [2]] Out-of-Pocket Limits are satisfied; [then Tier [X];] [100% thereafter.]]	[0% - 100% [until the [I Loss or Impairment of Speech or Hearing] [Tier [2]] Out-of-Pocket Limits are satisfied; [then Tier [X];] [100% thereafter.]]
[Tier [2]] [P Loss or Impairment of Speech or Hearing]] [Out-of-Pocket Limit] [each [Calendar Year] [Benefit Period] [Time Period] [Plan Year]] [Individual] [Per Covered Child]	[$0 - $25,000 / Not applicable]	[$0 - $25,000 / Not applicable]	[$0 - $25,000 / an additional $0 - $10,000]

[Family]	[$0 - $75,000 / Not applicable]	[$0 - $75,000 / Not applicable]	[$0 - $75,000 / an additional $0 - $30,000]
[Loss or Impairment of Speech or Hearing]] [Coinsurance] [Tier [X]]	[0% - 100% [until the [Loss or Impairment of Speech or Hearing] [Tier [X]] Out-of-Pocket Limits are satisfied;] [then Tier [X + [1]];] [100% thereafter.]]	[0% - 100% [until the [Loss or Impairment of Speech or Hearing] [Tier [X]] Out-of-Pocket Limits are satisfied;] [then Tier [X + [1]];] [100% thereafter.]]	[0% - 100% [until the [Loss or Impairment of Speech or Hearing] [Tier [X]] Out-of-Pocket Limits are satisfied;] [then Tier [X + [1]];] [100% thereafter.]]
[Tier [X]] [Loss or Impairment of Speech or Hearing]] [Out-of-Pocket Limit][each [Calendar Year] [Benefit Period] [Time Period] [Plan Year]] [Individual] [Per Covered Child]	[$0 - $25,000 / Not applicable]	[$0 - $25,000 / Not applicable]	[$0 - $25,000 / an additional $0 - $10,000]
[Family]	[$0 - $75,000 / Not applicable]	[$0 - $75,000 / Not applicable]	[$0 - $75,000 / an additional $0 - $30,000]
[[Loss or Impairment of Speech or Hearing]] Out-of-Pocket Limits] [Individual] [Per Covered Child]	[$XXX]	[$XXX]	[$XXX]
[Family]	[$XXX]	[$XXX]	[$XXX]
[Benefits for Loss or Impairment of Speech or Hearing Services are payable at [0-100%] [with a [$10-$100] Copayment] when a Designated Specialty Service Provider is used. If a Designated Specialty Service Provider is not used, [Covered Charges will be [paid at the [Non-][Participating] [or] [applicable] Coinsurance] [reduced by [$1 - $3,000] [1% - 50%]][limited to [$XXX] per [Calendar] [Plan] Year] [per Covered Person] [after the Covered Person has paid any applicable Copayment, Deductible or other fees.] [These limitations will apply to all treatment rendered by a provider that is not designated as a [Designated Specialty Service Provider] regardless of whether the provider is a [Network Provider,] [Participating Provider,] [or] [Select Participating Provider].]of whether the provider is a [Network Provider,] [Participating Provider,] [or] [Select Participating Provider			

BEN: 037.001.AR

Medical Foods:			
[All services, supplies and treatments apply to the [Outpatient] [and] [Calendar Year] [and] [Plan Year] [and] [Benefit Period] [Per Cause] [and] [Monthly] [and] [Daily] Maximum Benefit]			
[Subject to [Plan] [and] [Outpatient] [Integrated] Deductible and [Plan] [and] [Outpatient] Coinsurance [unless otherwise specified]]			
No benefits are available for the first {$2,400] of Covered Charges incurred by a Covered Person in a calendar year.			
	[Select Participating Provider Benefits]	**[Participating Provider Benefits / Network Provider Benefits]**	**[Non-[Select] Participating Provider Benefits/ Non-Participating Provider Benefits/ Non-Network Provider Benefits]**

[Medical Foods] [Coinsurance]	[0% - 100% [until the Out-of-Pocket Limits are satisfied;] [100% thereafter.]]	[0% - 100% [until the Out-of-Pocket Limits are satisfied;] [100% thereafter.]]	[0% - 100% [until the Out-of-Pocket Limits are satisfied;] [100% thereafter.]]
[Benefits for Family Planning Services are payable at [0-100%] [with a [$10-$100] Copayment] when a Designated Specialty Service Provider is used. If a Designated Specialty Service Provider is not used, [Covered Charges will be [paid at the [Non-][Participating] [or] [applicable] Coinsurance] [reduced by [$1 - $3,000] [1% - 50%]][limited to [$XXX] per [Calendar] [Plan] Year] [per Covered Person] [after the Covered Person has paid any applicable Copayment, Deductible or other fees.] [These limitations will apply to all treatment rendered by a provider that is not designated as a Designated Specialty Service Provider regardless of whether the provider is a [Network Provider,] [Participating Provider,] [or] [Select Participating Provider].]			

BEN: 038.001.AR

[**Accident Medical Expense** [**Reduced Plan Deductible**] **Benefit**:]			
[All services, supplies and treatments apply to the [Plan] [and] [Outpatient] [and] [Calendar Year] [Plan Year] [Benefit Period] [Per Cause] Maximum Benefit]			
[Subject to [Plan] [and] [Inpatient] [and] [Outpatient] [Integrated] [Per Cause] Deductible] and [Plan] [and] [Inpatient] [and] [Outpatient] Coinsurance [unless otherwise specified].]			
[We will pay up to [$XXX] per [Calendar Year] [Plan Year] [Benefit Period] [Per Cause][Accidental Injury] [Injury] for Covered Charges Incurred due to an Accidental Injury. After payment of this amount, Covered Charges will be subject to the [Plan] [and] [Inpatient] [and] [Outpatient] [Integrated] [Per Cause] Deductible] and [Plan] [and] [Inpatient] [and] [Outpatient] Coinsurance.]			
[Covered charges must be Incurred within [90] days of the Accident] [Injury]. [Covered Charges in excess of the Accident Medical Expense Benefit or rendered after the 90-day period will be subject to all the terms, limits and conditions of the plan.]			
[Accident Medical Expense is subject to the Accident Medical Expense Deductible [and Coinsurance] then Covered Charges are paid at [100%] up to [$XX]. Covered Charges are then subject to the [Plan] [and][Outpatient] [and] [Inpatient] [Integrated] [Per Cause] Deductible] and [Plan] [and][Outpatient] [and] [Inpatient]Coinsurance.]]			
[Your [Plan] [Individual] [Integrated] [Family] [Per Cause] Deductible] will be reduced by [$XXX] for Covered Charges Incurred due to an [Accidental Injury] [Injury],] [then subject to [Plan] [and][Outpatient] [and] [Inpatient] [Coinsurance]]			
[Accident Medical Expense Benefit Waiting Period is [XX days]]			
[Not Covered]			
	[Primary Care Physician / [Select] Participating Provider [Benefits]]	**[Participating Provider [Benefits] / Network Provider [Benefits]]**	**[Non-[Select] Participating Provider [Benefits]/ Non-Participating Provider [Benefits]/ Non-Network Provider [Benefits]]**
[Accident Medical Expense Benefit] Maximum [Lifetime] [Calendar Year] [Plan Year] [Benefit Period] [Per Cause] [Monthly] [Daily] Benefit]	[$XXX] [per Covered Person] [Per Covered Child]	[$XXX] [per Covered Person] [Per Covered Child]	[$XXX] [per Covered Person] [Per Covered Child]
[Accident Medical Expense Benefit Deductible] [Individual] [Per Covered Child]	[$XXX]	[$XXX]	[$XXX]
[Integrated] [Family]	[$XXX]	[$XXX]	[$XXX]
[The [Accident Medical Expense Benefit Deductible] does [not] apply to the Plan Deductible or Total Out-of-Pocket Limits.]			
[[Non-Participating] [Non-network] Provider Deductible is in addition to the [Participating] [Network] Provider Deductible.]			

[Once [[2] or more Covered Persons have collectively met] the maximum Family Deductible [has been met], no additional Deductible will be taken during the [Calendar Year] [Plan Year] [Benefit Period] [Time Period].]			
[Accident Medical Expense Benefit] [Coinsurance] [Tier [1]]	[0% - 100% [until the [Accident Medical Expense] [Tier [1]] Out-of-Pocket Limits are satisfied; [then Tier [2];] [100% thereafter.]]	[0% - 100% [until the [Accident Medical Expense] [Tier [1]] Out-of-Pocket Limits are satisfied; [then Tier [2];] [100% thereafter.]]	[0% - 100% [until the [Accident Medical Expense] [Tier [1]] Out-of-Pocket Limits are satisfied; [then Tier [2];] [100% thereafter.]]
[Tier [1]] [Accident Medical Expense Benefit] Out-of-Pocket Limit [each [Calendar Year] [Benefit Period] [Time Period] [Plan Year]] [Individual] [Per Covered Child]	[$0 - $25,000 / Not applicable]	[$0 - $25,000 / Not applicable]	[$0 - $25,000 / an additional $0 - $10,000]
[Family]	[$0 - $75,000 / Not applicable]	[$0 - $75,000 / Not applicable]	[$0 - $75,000 / an additional $0 - $30,000]
[Accident Medical Expense Benefit] [Coinsurance] [Tier [2]]	[0% - 100% [until the [Accident Medical Expense] [Tier [2]] Out-of-Pocket Limits are satisfied; [then Tier [X];] [100% thereafter.]]	[0% - 100% [until the [Accident Medical Expense] [Tier [2]] Out-of-Pocket Limits are satisfied; [then Tier [X];] [100% thereafter.]]	[0% - 100% [until the [Accident Medical Expense] [Tier [2]] Out-of-Pocket Limits are satisfied; [then Tier [X];] [100% thereafter.]]
[Tier [2]] [Accident Medical Expense Benefit] Out-of-Pocket Limit [each [Calendar Year] [Benefit Period] [Time Period] [Plan Year]] [Individual] [Per Covered Child]	[$0 - $25,000 / Not applicable]	[$0 - $25,000 / Not applicable]	[$0 - $25,000 / an additional $0 - $10,000]
[Family]	[$0 - $75,000 / Not applicable]	[$0 - $75,000 / Not applicable]	[$0 - $75,000 / an additional $0 - $30,000]
[Accident Medical Expense Benefit] [Coinsurance] [Tier [X]]	[0% - 100% [until the [Accident Medical Expense] [Tier [X]] Out-of-Pocket Limits are satisfied;] [then Tier [X + [1]];] [100% thereafter.]]	[0% - 100% [until the [Accident Medical Expense] [Tier [X]] Out-of-Pocket Limits are satisfied;] [then Tier [X + [1]];] [100% thereafter.]]	[0% - 100% [until the [Accident Medical Expense] [Tier [X]] Out-of-Pocket Limits are satisfied;] [then Tier [X + [1]];] [100% thereafter.]]
[Tier [X]] [Accident Medical Expense Benefit] Out-of-Pocket Limit [each [Calendar Year] [Benefit Period] [Time Period] [Plan Year]] [Individual] [Per Covered Child]	[$0 - $25,000 / Not applicable]	[$0 - $25,000 / Not applicable]	[$0 - $25,000 / an additional $0 - $10,000]

[Family]	[$0 - $75,000 / Not applicable]	[$0 - $75,000 / Not applicable]	[$0 - $75,000 / an additional $0 - $30,000]
[[Accident Medical Expense] Out-of-Pocket Limits] [Individual] [Per Covered Child] [Family]	[$XXX] [$XXX]	[$XXX] [$XXX]	[$XXX] [$XXX]

BEN: 040.001.001.GE

[[**Diagnostic Imaging Services**] [**and**] [**Laboratory Services**]:]			
[All services, supplies and treatments apply to the [Inpatient][Outpatient] [Calendar Year] [Plan Year] [Benefit Period] [Per Cause] Maximum Benefit]			
[Subject to [Plan] [Outpatient][Inpatient] [Integrated] Deductible and [Plan] [Outpatient] [Inpatient]Coinsurance [unless otherwise specified]]			
[[Plan] [Integrated] [Per Cause] Deductible] [and Co-insurance] will be waived for the first [$XXX~~250~~] of Covered Services] [per] [Covered Person] [covered child] [Family] [per [Calendar Year] [Plan Year] [Benefit Period] [Per Cause]] [after a [12 month] [365 day] Benefit Waiting Period].]			
[[Diagnostic Imaging Services] [and] [Laboratory Services] Benefit Waiting Period is [[12] [months] [[365] days].]			
[Limited to [Diagnostic Imaging Services] [and] [Laboratory Services] associated with an Inpatient Stay when Covered Charges are Incurred within [14 days] of admission.]			
[Includes [1] screening mammography exam per Benefit Period for a covered female age [35] or over.] [The maximum benefit for a mammography screening is [$50 - $500~~60.00~~].]			
[Diagnostic Imaging Services] [and] [Laboratory Services] are limited to a [Calendar Year] [Plan Year] [Benefit Period] [Per Cause] [Monthly] [Daily] Maximum of [$XXX] [per] [Covered Person] [covered child] [Family]]			
[Not Covered]			
	[[Select] Participating Provider [Benefits]]	**[Participating Provider [Benefits] / Network Provider [Benefits]]**	**[Non-[Select] Participating Provider [Benefits]/ Non-Participating Provider [Benefits]/ Non-Network Provider [Benefits]]**
[[Diagnostic Imaging Services] Maximum Benefit]	[$XXX] [[per] [Covered Person][Covered Child].]	[$XXX] [[per] [Covered Person][Covered Child].]	[$XXX] [[per] [Covered Person][Covered Child].]
[[Diagnostic Imaging Services] Maximum Benefit] [due to an [Accidental Injury] [Injury] [or] [underlying Sickness]]	[$XXX][[per] [Covered Person][Covered Child].]	[$XXX] [[per] [Covered Person][Covered Child].]	[$XXX] [[per] [Covered Person][Covered Child].]
[[Diagnostic Imaging Services] [and] [Laboratory Services] [Per Cause] Deductible]] [Individual] [Integrated] [Family]	[$XXX] [$XXX]	[$XXX] [$XXX]	[$XXX] [$XXX]
[The [Diagnostic Imaging Services] [and] [Laboratory Services] Deductible] does [not] apply to the			

[Plan][Outpatient][Inpatient][Integrated] [Per Cause] Deductible] or Total Out-of-Pocket Limits.]			
[[Non-Participating] [Non-Network] [Retail Health Clinic] Provider Deductible is in addition to the [Participating] [Network] Provider Deductible.]			
[Once [[2] or more Covered Persons have collectively met] the maximum Family Deductible [has been met]], no additional Deductible will be taken during the [Calendar Year] [Plan Year] [Benefit Period] [Time Period].]			
[[Diagnostic Imaging Services] [and] [Laboratory Services]] [Coinsurance] [Tier [1]]	[0% - 100% [until the [[[Diagnostic Imaging Services] [and] [Laboratory Services]] [Tier [1]] Out-of-Pocket Limits are satisfied; [then Tier [2];] [100% thereafter.]]	[0% - 100% [until the [[[Diagnostic Imaging Services] [and] [Laboratory Services]] [Tier [1]] Out-of-Pocket Limits are satisfied; [then Tier [2];] [100% thereafter.]]	[0% - 100% [until the [[Diagnostic Imaging Services] [and] [Laboratory Services] [Tier [1]] Out-of-Pocket Limits are satisfied; [then Tier [2];] [100% thereafter.]]
[Tier [1]] [[Diagnostic Imaging Services] [and] [Laboratory Services]][Out-of-Pocket Limit] [each [Calendar Year] [Benefit Period] [Time Period] [Plan Year]] [Individual] [Family]	[$0 - $25,000 / Not applicable] [$0 - $75,000 / Not applicable]	[$0 - $25,000 / Not applicable] [$0 - $75,000 / Not applicable]	[$0 - $25,000 / an additional $0 - $10,000] [$0 - $75,000 / an additional $0 - $30,000]
[[Diagnostic Imaging Services] [and] [Laboratory Services] [Coinsurance]] [Tier [2]]	[0% - 100% [until the [[[Diagnostic Imaging Services] [and] [Laboratory Services] [Tier [2]] Out-of-Pocket Limits are satisfied; [then Tier [X];] [100% thereafter.]]	[0% - 100% [until the [[Diagnostic Imaging Services] [and] [Laboratory Services] [Tier [2]] Out-of-Pocket Limits are satisfied; [then Tier [X];] [100% thereafter.]]	[0% - 100% [until the [[Diagnostic Imaging Services] [and] [Laboratory Services] [Tier [2]] Out-of-Pocket Limits are satisfied; [then Tier [X];] [100% thereafter.]]
[Tier [2]] [[Diagnostic Imaging Services] [and] [Laboratory Services]] [Out-of-Pocket Limit][each [Calendar Year] [Benefit Period] [Time Period] [Plan Year]] [Individual] [Family]	[$0 - $25,000 / Not applicable] [$0 - $75,000 / Not applicable]	[$0 - $25,000 / Not applicable] [$0 - $75,000 / Not applicable]	[$0 - $25,000 / an additional $0 - $10,000] [$0 - $75,000 / an additional $0 - $30,000]
[[Diagnostic Imaging Services] [and] [Laboratory Services] [Coinsurance]] [Tier [X]]	[0% - 100% [until the [[Diagnostic Imaging Services] [and] [Laboratory Services]] [Tier [X]] Out-of-Pocket Limits are satisfied;] [then Tier [X + [1]];] [100% thereafter.]]	[0% - 100% [until the [[Diagnostic Imaging Services] [and] [Laboratory Services] [Tier [X]] Out-of-Pocket Limits are satisfied;] [then Tier [X + [1]];] [100%	[0% - 100% [until the [[Diagnostic Imaging Services] [and] [Laboratory Services] [Tier [X]] Out-of-Pocket Limits are satisfied;] [then Tier [X + [1]];] [100% thereafter.]]

		thereafter.]]	
[Tier [X]] [[Diagnostic Imaging Services] [and] [Laboratory Services]][Out-of-Pocket Limit][each [Calendar Year] [Benefit Period] [Time Period] [Plan Year]] [Individual] [Family]	[$0 - $25,000 / Not applicable] [$0 - $75,000 / Not applicable]	[$0 - $25,000 / Not applicable] [$0 - $75,000 / Not applicable]	[$0 - $25,000 / an additional $0 - $10,000] [$0 - $75,000 / an additional $0 - $30,000]
[[[Diagnostic Imaging Services] [and] [Laboratory Services] [Out-of-Pocket Limits]] [Individual] [Integrated] [Family]	[$XXX] [$XXX]	[$XXX] [$XXX]	[$XXX] [$XXX]
[Benefits for [Diagnostic Imaging Services] [and] [Laboratory Services] are payable at [0-100%] [with a [$10-$100] Copayment] when a Designated Specialty Service Provider is used. If a Designated Specialty Service Provider is not used, [Covered Charges will be [paid at the [Non-][Participating] [or] [applicable] Coinsurance] [reduced by [$1 - $3,000] [1% - 50%]] [limited to [$XXX] per [Calendar] [Plan] Year] [per Covered Person] [after the Covered Person has paid any applicable Copayment, Deductible or other fees.]] [These limitations will apply to all treatment rendered by a provider that is not designated as a [Designated Specialty Service Provider] regardless of whether the provider is a [Network Provider,] [Participating Provider,] [or] [Select Participating Provider].]			

BEN: 045.001.001.GE

[**Outpatient Physical Medicine Services**:]			
[All services, supplies and treatments apply to the [Outpatient] [Calendar Year] [Plan Year] [Benefit Period] [Per Cause] Maximum Benefit]			
[Subject to [Outpatient] [Plan] [Integrated] [Per Cause] Deductible] and [Outpatient] [Plan] Coinsurance [unless otherwise specified]]			
[Benefits are limited to an Outpatient Physical Medicine Services Maximum [Lifetime] [Calendar Year] [Plan Year] [Monthly] [Daily] [Benefit Period] [Per Cause] Benefit of [$XXX] [per] [Covered Person] [covered child] [Family] [unless due to an [Accidental Injury] [Injury] [or] [underlying Sickness] [then We will pay up to a [$XXX] Maximum [Lifetime] [Calendar Year] [Plan Year] [Benefit Period] [Per Cause] [Monthly] [Daily] Benefit] [per] [Covered Person] [covered child] [Family]]			
[We will pay [up to] an Outpatient Physical Medicine Services Maximum of [$XXX] [per] [Covered Person] [covered child] [Family] [per [day] [episode]][unless due to an [Accidental Injury] [Injury] [or] [underlying Sickness] [then We will pay up to [$XXX] [per [day] [episode]]			
[Benefits for Outpatient Physical Medicine Services are limited to [1-20~~2~~] visits each [Calendar Year] [Plan Year] [Benefit Period] [Per Cause] per Covered Person with a maximum payment of [$25 - $200~~$50~~] per visit]			
[Chiropractic Coverage is] [Adjustments and manipulations are] limited to a Maximum [Lifetime] [Calendar Year][Plan Year] [Monthly] [Daily] [Benefit Period] [Per Cause] Benefit of [$XXX] [per] [Covered Person][Family]]			
[Outpatient Physical Medicine Services Benefits Waiting Period is [[12] months]][[365] days]			
[Not Covered]			
	[[Select] Participating Provider [Benefits]]	**[Participating Provider [Benefits] / Network**	**[Non-[Select] Participating Provider [Benefits]/ Non-**

		Provider [Benefits]]	**Participating Provider [Benefits]/ Non-Network Provider [Benefits]]**
[[Outpatient Physical Medicine Services] Maximum Benefit]	[$XXX] [per] [Covered Person] [covered child] [Family] [per [day] [episode]]	[$XXX] [per] [Covered Person] [covered child] [Family] [per [day] [episode]]	[$XXX] [per] [Covered Person] [covered child] [Family] [per [day] [episode]]
[[Outpatient Physical Medicine Services] [due to an [Accidental Injury] [Injury] [or] [underlying Sickness]]	[$XXX] [per] [Covered Person] [covered child] [Family] [per [day] [episode]]	[$XXX] [per] [Covered Person] [covered child] [Family] [per [day] [episode]]	[$XXX] [per] [Covered Person] [covered child] [Family] [per [day] [episode]]
[Outpatient Physical Medicine Services [Per Cause] Deductible]] [Individual] [Integrated] [Family]	[$XXX] [$XXX]	[$XXX] [$XXX]	[$XXX] [$XXX]
[The [Outpatient Physical Medicine Services Deductible] does [not] apply to the Plan Deductible or Total Out-of-Pocket Limits.]			
[[Non-Participating] [Non-network] Provider Deductible is in addition to the [Participating] [Network] Provider Deductible.]			
[Once [[2] or more Covered Persons have collectively met] the maximum Family Deductible [has been met], no additional Deductible will be taken during the [Calendar Year] [Plan Year] [Benefit Period] [Time Period].]			
[Outpatient Physical Medicine Services] [Copayment]	[None / $XXX per Outpatient Physical Medicine Services]	[None / $XXX per Outpatient Physical Medicine Services]	[None / $XXX per Outpatient Physical Medicine Services]
[Outpatient Physical Medicine Services] [Coinsurance] [Tier [1]]	[0% - 100% [until the [Outpatient Physical Medicine Services] [Tier [1]] Out-of-Pocket Limits are satisfied; [then Tier [2];] [100% thereafter.]]	[0% - 100% [until the [Outpatient Physical Medicine Services] [Tier [1]] Out-of-Pocket Limits are satisfied; [then Tier [2];] [100% thereafter.]]	[0% - 100% [until the [Outpatient Physical Medicine Services] [Tier [1]] Out-of-Pocket Limits are satisfied; [then Tier [2];] [100% thereafter.]]
[Tier [1]] [Outpatient Physical Medicine Services] [Out-of-Pocket Limit] [each [Calendar Year] [Benefit Period] [Time Period] [Plan Year]] [Individual] [Family]	[$0 - $25,000 / Not applicable] [$0 - $75,000 / Not applicable]	[$0 - $25,000 / Not applicable] [$0 - $75,000 / Not applicable]	[$0 - $25,000 / an additional $0 - $10,000] [$0 - $75,000 / an additional $0 - $30,000]
[Outpatient Physical Medicine Services] [Coinsurance] [Tier [2]]	[0% - 100% [until the [Outpatient Physical Medicine Services] [Tier [2]] Out-of-Pocket Limits are satisfied; [then Tier [X];] [100%	[0% - 100% [until the [Outpatient Physical Medicine Services] [Tier [2]] Out-of-Pocket Limits are satisfied; [then Tier [X];] [100%	[0% - 100% [until the [Outpatient Physical Medicine Services] [Tier [2]] Out-of-Pocket Limits are satisfied; [then Tier [X];] [100%

	thereafter.]]	thereafter.]]	thereafter.]]
[Tier [2]] [Outpatient Physical Medicine Services] [Out-of-Pocket Limit][each [Calendar Year] [Benefit Period] [Time Period] [Plan Year]] [Individual] [Family]	[$0 - $25,000 / Not applicable] [$0 - $75,000 / Not applicable]	[$0 - $25,000 / Not applicable] [$0 - $75,000 / Not applicable]	[$0 - $25,000 / an additional $0 - $10,000] [$0 - $75,000 / an additional $0 - $30,000]
[Outpatient Physical Medicine Services] [Coinsurance] [Tier [X]]	[0% - 100% [until the [Outpatient Physical Medicine Services] [Tier [X]] Out-of-Pocket Limits are satisfied;] [then Tier [X + [1]];] [100% thereafter.]]	[0% - 100% [until the [Outpatient Physical Medicine Services] [Tier [X]] Out-of-Pocket Limits are satisfied;] [then Tier [X + [1]];] [100% thereafter.]]	[0% - 100% [until the [Outpatient Physical Medicine Services] [Tier [X]] Out-of-Pocket Limits are satisfied;] [then Tier [X + [1]];] [100% thereafter.]]
[Tier [X]] [Outpatient Physical Medicine Services] [Out-of-Pocket Limit][each [Calendar Year] [Benefit Period] [Time Period] [Plan Year]] [Individual] [Family]	[$0 - $25,000 / Not applicable] [$0 - $75,000 / Not applicable]	[$0 - $25,000 / Not applicable] [$0 - $75,000 / Not applicable]	[$0 - $25,000 / an additional $0 - $10,000] [$0 - $75,000 / an additional $0 - $30,000]
[[Outpatient Physical Medicine Services] [Out-of-Pocket Limits]] [Individual] [Integrated] [Family]	[$XXX] [$XXX]	[$XXX] [$XXX]	[$XXX] [$XXX]
[Benefits for Outpatient Physical Medicine Services are payable at [0-100%] [with a [$10-$100] Copayment] when a Designated Specialty Service Provider is used. If a Designated Specialty Service Provider is not used, [Covered Charges will be [paid at the [Non-][Participating] [or] [applicable] Coinsurance] [reduced by [$1 - $3,000] [1% - 50%]][limited to [$XXX] per [Calendar] [Plan] Year] [per Covered Person] [after the Covered Person has paid any applicable Copayment, Deductible or other fees.] [These limitations will apply to all treatment rendered by a provider that is not designated as a [Designated Specialty Service Provider] regardless of whether the provider is a [Network Provider,] [Participating Provider,] [or] [Select Participating Provider].]			

BEN: 050.001.001.GE

[**Outpatient Alternative Medicine Services**:]
[All services, supplies and treatments apply to the [Outpatient] [and] [Calendar Year] [and] [Plan Year] [Benefit Period] [Per Cause] Maximum Benefit]

[Subject to [Plan] [and] [Outpatient] [Integrated] [Per Cause] Deductible] and [Plan] [and] [Outpatient] Coinsurance [unless otherwise specified]]			
[Benefits for Outpatient Alternative Medicine Services are limited to a Maximum [Lifetime] [Calendar Year] [Plan Year] [Benefit Period] [Per Cause] [Monthly] [Daily] Benefit of [$20 - $5,000~~$2,000~~]]			
[Benefits for Outpatient Alternative Medicine Services are limited to a Maximum Benefit of [[$XX] for each visit[up to [XX] visits]] [up to [$XXX] each [Calendar] [Plan] Year] [Benefit Period] [per Covered Person]]			
[Outpatient Alternative Medicine Services Benefit Waiting Period is [[6] [months] [[180] days].]			
[Not Covered]			
	[[Select] Participating Provider [Benefits]]	**[Participating Provider [Benefits] / Network Provider [Benefits]]**	**[Non-[Select] Participating Provider [Benefits]/ Non-Participating Provider [Benefits]/ Non-Network Provider [Benefits]]**
[Outpatient Alternative Medicine Services]] Maximum [Lifetime] [Calendar Year] [Plan Year] [Benefit Period] [Per Cause] [Monthly] [Daily] Benefit]	[$XXX] [per Covered Person]	[$XXX] [per Covered Person]	[$XXX] [per Covered Person]
[Outpatient Alternative Medicine Services Deductible] [Individual] [Integrated] [Family]	[$XXX] [$XXX]	[$XXX] [$XXX]	[$XXX] [$XXX]
[The [Outpatient Alternative Medicine Services Deductible] does [not] apply to the Plan Deductible or Total Out-of-Pocket Limits.]			
[[Non-Participating] [Non-network] Provider Deductible is in addition to the [Participating] [Network] Provider Deductible.]			
[Once [[2] or more Covered Persons have collectively met] the maximum Family Deductible [[has been met], no additional Deductible will be taken during the [Calendar Year] [Plan Year] [Benefit Period] [Time Period].]			
[Access] [Fee]	[None / $XXX per Alternative Medical Care Service]	[None / $XXX per Alternative Medical Care Service]	[None / $XXX per Alternative Medical Care Service]
[Copayment]	[None / $XXX per Alternative Medical Care Service]	[None / $XXX per Alternative Medical Care Service]	[None / $XXX per Alternative Medical Care Service]
[[Outpatient Alternative Medicine Services] [Coinsurance] [Tier [1]]	[0% - 100% [until the [Outpatient Alternative Medicine Services] [Tier [1]] Out-of-Pocket Limits are satisfied; [then Tier [2];] [100% thereafter.]]	[0% - 100% [until the [Outpatient Alternative Medicine Services] [Tier [1]] Out-of-Pocket Limits are satisfied; [then Tier [2];] [100% thereafter.]]	[0% - 100% [until the [Outpatient Alternative Medicine Services] [Tier [1]] Out-of-Pocket Limits are satisfied; [then Tier [2];] [100% thereafter.]]
[Tier [1]] [[Outpatient Alternative Medicine Services]Out-of-Pocket Limit [each [Calendar Year] [Benefit Period] [Time Period] [Plan Year]] [Individual]	[$0 - $25,000 / Not applicable]	[$0 - $25,000 / Not applicable]	[$0 - $25,000 / an additional $0 - $10,000]

[Family]	[$0 - $75,000 / Not applicable]	[$0 - $75,000 / Not applicable]	[$0 - $75,000 / an additional $0 - $30,000]
[[Outpatient Alternative Medicine Services] [Coinsurance] [Tier [2]]	[0% - 100% [until the [Outpatient Alternative Medicine Services] [Tier [2]] Out-of-Pocket Limits are satisfied; [then Tier [X];] [100% thereafter.]]	[0% - 100% [until the [Outpatient Alternative Medicine Services] [Tier [2]] Out-of-Pocket Limits are satisfied; [then Tier [X];] [100% thereafter.]]	[0% - 100% [until the [Outpatient Alternative Medicine Services] [Tier [2]] Out-of-Pocket Limits are satisfied; [then Tier [X];] [100% thereafter.]]
[Tier [2]] [[Outpatient Alternative Medicine Services]Out-of-Pocket Limit [each [Calendar Year] [Benefit Period] [Time Period] [Plan Year]] [Individual]	[$0 - $25,000 / Not applicable]	[$0 - $25,000 / Not applicable]	[$0 - $25,000 / an additional $0 - $10,000]
[Family]	[$0 - $75,000 / Not applicable]	[$0 - $75,000 / Not applicable]	[$0 - $75,000 / an additional $0 - $30,000]
[[Outpatient Alternative Medicine Services] [Coinsurance] [Tier [X]]	[0% - 100% [until the [Outpatient Alternative Medicine Services] [Tier [X]] Out-of-Pocket Limits are satisfied;] [then Tier [X + [1]];] [100% thereafter.]]	[0% - 100% [until the [Outpatient Alternative Medicine Services] [Tier [X]] Out-of-Pocket Limits are satisfied;] [then Tier [X + [1]];] [100% thereafter.]]	[0% - 100% [until the [Outpatient Alternative Medicine Services] [Tier [X]] Out-of-Pocket Limits are satisfied;] [then Tier [X + [1]];] [100% thereafter.]]
[Tier [X]] [[Outpatient Alternative Medicine Services]Out-of-Pocket Limit [each [Calendar Year] [Benefit Period] [Time Period] [Plan Year]] [Individual]	[$0 - $25,000 / Not applicable]	[$0 - $25,000 / Not applicable]	[$0 - $25,000 / an additional $0 - $10,000]
[Family]	[$0 - $75,000 / Not applicable]	[$0 - $75,000 / Not applicable]	[$0 - $75,000 / an additional $0 - $30,000]
[[Outpatient Alternative Medicine Services] [Out-of-Pocket Limits]] [Individual]	[$XXX]	[$XXX]	[$XXX]
[Family]	[$XXX]	[$XXX]	[$XXX]
[Benefits for [Outpatient Alternative Medicine Services] are payable at [0-100%] [with a [$10-$100] Copayment] when a [Designated Specialty Service Provider] is used. If a [Designated Specialty Service Provider] is not used, [Covered Charges will be [paid at the [Non-][Participating] [or] [applicable] Coinsurance] [reduced by [$1 - $3,000] [1% -			

50%]][limited to [$XXX] per [Calendar] [Plan] Year] [per Covered Person] [after the Covered Person has paid any applicable Copayment, Deductible or other fees.] [These limitations will apply to all treatment rendered by a provider that is not designated as a [Designated Specialty Service Provider] regardless of whether the provider is a [Network Provider,] [Participating Provider,] [or] [Select Participating Provider].]

BEN: 055.001.001.GE

[**Durable Medical Equipment and Personal Medical Equipment**:]			
[All services, supplies and treatments apply to the [Outpatient] [Calendar Year] [Plan Year] [Benefit Period] [Per Cause] Maximum Benefit]]			
[Subject to [Plan] [Outpatient] [Integrated] Deductible and [Plan] [Outpatient] Coinsurance [unless otherwise specified]]			
[[Durable Medical Equipment] [and] [Personal Medical Equipment] Benefits are limited to a [Lifetime][Calendar Year][Plan Year] [Benefit Period] [Per Cause] [Monthly] [Daily] Maximum of [$XXX] [per] [Covered Person][Covered Child].]			
[Wheelchairs apply to the [Outpatient] [Calendar Year] [Plan Year] [Benefit Period] [Per Cause] Maximum Benefit]]			
[Wheelchairs will be subject to [Plan] [and] [Outpatient] [Integrated] [Per Cause] Deductible and [Plan] [and] [Outpatient] Coinsurance [unless otherwise specified]]			
[Not Covered]			
	[[Select] Participating Provider [Benefits]]	**[Participating Provider [Benefits] / Network Provider [Benefits]]**	**[Non-[Select] Participating Provider [Benefits]/ Non-Participating Provider [Benefits]/ Non-Network Provider [Benefits]]**
[[Durable Medical Equipment and Personal Medical Equipment] Maximum Benefit]	[$XXX] [[per] [Covered Person][Covered Child].]	[$XXX] [per] [Covered Person][Covered Child].]	[$XXX] [per] [Covered Person][Covered Child].]
[[Durable Medical Equipment and Personal Medical Equipment] Maximum Benefit] [due to an [Accidental Injury] [Injury] [or] [underlying Sickness]]	[$XXX] [per] [Covered Person][Covered Child].]	[$XXX] [per] [Covered Person][Covered Child].]	[$XXX] [per] [Covered Person][Covered Child].]
[Durable Medical Equipment and Personal Medical Equipment [Per Cause] Deductible] [Individual] [Integrated] [Family]	[$XXX] [$XXX]	[$XXX] [$XXX]	[$XXX] [$XXX]
[The [Durable Medical Equipment and Personal Medical Equipment Deductible] does [not] apply to the Plan Deductible or Total Out-of-Pocket Limits.]			
[[Non-Participating] [Non-Network] Provider Deductible is in addition to the [Participating] [Network] Provider Deductible.]			
[Once [[2] or more Covered Persons have collectively met] the maximum Family Deductible has been met], no additional Deductible will be taken during the [Calendar Year] [Plan Year] [Benefit Period] [Time Period].]			
[Personal Medical Equipment]	[$[XXXX] Maximum [Lifetime] [Calendar Year] [Plan Year] [Monthly] Benefit	[$[XXXX] Maximum [Lifetime] [Calendar Year] [Plan Year] [Monthly] Benefit	[$[XXXX] Maximum [Lifetime] [Calendar Year] [Plan Year] [Monthly] Benefit
[Initial] [Permanent] [Temporary] [Basic] [Artificial] [Limb] [or] [Eye]	[$[XXXX] Maximum [Lifetime] [Calendar Year] [Plan Year]	[$[XXXX] Maximum [Lifetime] [Calendar Year] [Plan Year]	[$[XXXX] Maximum [Lifetime] [Calendar Year] [Plan Year]

	[Monthly] Benefit	[Monthly] Benefit	[Monthly] Benefit
[Durable Medical Equipment]	[$[XXXX] Maximum [Lifetime] [Calendar Year] [Plan Year] [Monthly] Benefit	[$[XXXX] Maximum [Lifetime] [Calendar Year] [Plan Year] [Monthly] Benefit	[$[XXXX] Maximum [Lifetime] [Calendar Year] [Plan Year] [Monthly] Benefit
~~[Wheelchairs]~~	~~[$[XXXX] Maximum [Lifetime] [Calendar Year] [Plan Year] [Monthly] Benefit~~	~~[$[XXXX] Maximum [Lifetime] [Calendar Year] [Plan Year] [Monthly] Benefit~~	~~[$[XXXX] Maximum [Lifetime] [Calendar Year] [Plan Year] [Monthly] Benefit~~
[Durable Medical Equipment and Personal Medical Equipment] [Coinsurance] [Tier [1]]	[0% - 100% [until the [Durable Medical Equipment and Personal Medical Equipment] [Tier [1]] Out-of-Pocket Limits are satisfied; [then Tier [2];] [100% thereafter.]]	[0% - 100% [until the [Durable Medical Equipment and Personal Medical Equipment] [Tier [1]] Out-of-Pocket Limits are satisfied; [then Tier [2];] [100% thereafter.]]	[0% - 100% [until the [Durable Medical Equipment and Personal Medical Equipment] [Tier [1]] Out-of-Pocket Limits are satisfied; [then Tier [2];] [100% thereafter.]]
[Tier [1]] [Durable Medical Equipment and Personal Medical Equipment] [Out-of-Pocket Limit][each [Calendar Year] [Benefit Period] [Time Period] [Plan Year]] [Individual] [Family]	[$0 - $25,000 / Not applicable] [$0 - $75,000 / Not applicable]	[$0 - $25,000 / Not applicable] [$0 - $75,000 / Not applicable]	[$0 - $25,000 / an additional $0 - $10,000] [$0 - $75,000 / an additional $0 - $30,000]
[Durable Medical Equipment and Personal Medical Equipment] [Coinsurance] [Tier [2]]	[0% - 100% [until the [Durable Medical Equipment and Personal Medical Equipment] [Tier [2]] Out-of-Pocket Limits are satisfied; [then Tier [X];] [100% thereafter.]]	[0% - 100% [until the [Durable Medical Equipment and Personal Medical Equipment] [Tier [2]] Out-of-Pocket Limits are satisfied; [then Tier [X];] [100% thereafter.]]	[0% - 100% [until the [Durable Medical Equipment and Personal Medical Equipment] [Tier [2]] Out-of-Pocket Limits are satisfied; [then Tier [X];] [100% thereafter.]]
[Tier [2]] [Durable Medical Equipment and Personal Medical Equipment] [Out-of-Pocket Limit] [each [Calendar Year] [Benefit Period] [Time Period] [Plan Year]] [Individual] [Family]	[$0 - $25,000 / Not applicable] [$0 - $75,000 / Not applicable]	[$0 - $25,000 / Not applicable] [$0 - $75,000 / Not applicable]	[$0 - $25,000 / an additional $0 - $10,000] [$0 - $75,000 / an additional $0 - $30,000]

[Durable Medical Equipment and Personal Medical Equipment] [Coinsurance] [Tier [X]]	[0% - 100% [until the [Durable Medical Equipment and Personal Medical Equipment] [Tier [X]] Out-of-Pocket Limits are satisfied;] [then Tier [X + [1]];] [100% thereafter.]]	[0% - 100% [until the [Durable Medical Equipment and Personal Medical Equipment] [Tier [X]] Out-of-Pocket Limits are satisfied;] [then Tier [X + [1]];] [100% thereafter.]]	[0% - 100% [until the [Durable Medical Equipment and Personal Medical Equipment] [Tier [X]] Out-of-Pocket Limits are satisfied;] [then Tier [X + [1]];] [100% thereafter.]]
[Tier [X]] [Durable Medical Equipment and Personal Medical Equipment] [Out-of-Pocket Limit] [each [Calendar Year] [Benefit Period] [Time Period] [Plan Year]] [Individual] [Family]	[$0 - $25,000 / Not applicable] [$0 - $75,000 / Not applicable]	[$0 - $25,000 / Not applicable] [$0 - $75,000 / Not applicable]	[$0 - $25,000 / an additional $0 - $10,000] [$0 - $75,000 / an additional $0 - $30,000]
[[Durable Medical Equipment and Personal Medical Equipment] Out-of-Pocket Limits] [Individual] [Family]	[$XXX] [$XXX]	[$XXX] [$XXX]	[$XXX] [$XXX]
[[Benefits for [Durable Medical Equipment and Personal Medical Equipment] are payable at [0-100%] [with a [$10-$100] Copayment] when a [Designated Specialty Service Provider] is used. If a Designated Specialty Service Provider is not used, [Covered Charges will be [paid at the [Non-][Participating] [or] [applicable] Coinsurance] [reduced by [$1 - $3,000] [1% - 50%]] [limited to [$XXX] per [Calendar] [Plan] Year] [per Covered Person] [after the Covered Person has paid any applicable Copayment, Deductible or other fees.] [These limitations will apply to all treatment rendered by a provider that is not designated as a Designated Specialty Service Provider] regardless of whether the provider is a [Network Provider,] [Participating Provider,] [or] [Select Participating Provider].]			

BEN: 060.001.001.GE

[**Maternity Care Services**:]			
[All services, supplies and treatments apply to the [Inpatient] [and] [Outpatient] [and] [Calendar Year] [Plan Year] [Benefit Period] [Per Cause] Maximum Benefit]			
[Subject to [Plan] [and] [Inpatient] [and] [Outpatient] [Integrated] Deductible and [Plan] [and] [Inpatient] [and] [Outpatient] Coinsurance [unless otherwise specified] [and any other plan provisions in the Benefit Summary].]			
[Benefits are limited to a Maximum [Lifetime] [Calendar Year] [Plan Year] [Monthly] [Daily] [Benefit Period] [Per Cause] Benefit of [$XXX] [per Covered Person]]			
[[Maternity Care Services] Benefit Waiting Period is [[12] months] [[30-365] days]]			
[Benefits will be reduced by [50%] if conception occurs during the [Benefit Waiting Period][first Calendar Year of the policy]]			
[Not Covered]			
	[[Select] Participating Provider [Benefits]]	**[Participating Provider [Benefits] / Network Provider [Benefits]]**	**[Non-[Select] Participating Provider [Benefits]/ Non-Participating Provider [Benefits]/ Non-Network Provider**

			[Benefits]]
[[Maternity Care Services] Maximum [Lifetime] [Calendar Year] [Plan Year] [Benefit Period] [Per Cause] [Monthly] [Daily] Benefit]	[$XXX] [per Covered Person]	[$XXX] [per Covered Person]	[$XXX] [per Covered Person]
[[Maternity Care Services] Maximum [Lifetime] [Calendar Year] [Plan Year] [Benefit Period] [Per Cause] [Monthly] [Daily] Benefit] [due to an [Accidental Injury] [Injury] [or] [underlying Sickness]]	[$XXX] [per Covered Person]	[$XXX] [per Covered Person]	[$XXX] [per Covered Person]
[Maternity Care Services Deductible] [Individual] [Integrated] [Family]	[$XXX] [$XXX]	[$XXX] [$XXX]	[$XXX] [$XXX]
[Maternity Care Services Deductible][if conception occurs after the Benefit Waiting Period expires] [Individual]	[$XXX] [Subject to plan Deductible and Coinsurance]	[$XXX] [Subject to plan Deductible and Coinsurance]	[$XXX] [Subject to plan Deductible and Coinsurance]
[Maternity Care Services Deductible] if conception occurs before the Benefit Waiting Period expires] [Individual]	[$XXX] [Subject to plan Deductible and Coinsurance]	[$XXX] [Subject to plan Deductible and Coinsurance]	[$XXX] [Subject to plan Deductible and Coinsurance]
[The [Maternity Care Services Deductible] does [not] apply to the Plan Deductible or Total Out-of-Pocket Limits.]			
[[Non-Participating] [Non-network] Provider Deductible is in addition to the [Participating] [Network] Provider Deductible.]			
[Once [[2] or more Covered Persons have collectively met] the maximum Family Deductible [has been met], no additional Deductible will be taken during the [Calendar Year] [Plan Year] [Benefit Period] [Time Period].]			
[Maternity Care Services] [Coinsurance] [Tier [1]]	[0% - 100% [until the [Maternity Care Services] [Tier [1]] Out-of-Pocket Limits are satisfied; [then Tier [2];] [100% thereafter.]]	[0% - 100% [until the [Maternity Care Services] [Tier [1]] Out-of-Pocket Limits are satisfied; [then Tier [2];] [100% thereafter.]]	[0% - 100% [until the [Maternity Care Services] [Tier [1]] Out-of-Pocket Limits are satisfied; [then Tier [2];] [100% thereafter.]]
[Tier [1]] [Maternity Care Services] [Out-of-Pocket Limit][each [Calendar Year] [Benefit Period] [Time Period] [Plan Year]] [Individual] [Family]	[$0 - $25,000 / Not applicable] [$0 - $75,000 / Not applicable]	[$0 - $25,000 / Not applicable] [$0 - $75,000 / Not applicable]	[$0 - $25,000 / an additional $0 - $10,000] [$0 - $75,000 / an additional $0 - $30,000]
[Maternity Care Services] [Coinsurance] [Tier [2]]	[0% - 100% [until the [Maternity Care Services] [Tier [2]] Out-of-Pocket Limits are satisfied; [then Tier	[0% - 100% [until the [Maternity Care Services] [Tier [2]] Out-of-Pocket Limits are satisfied; [then Tier [X];] [100%	[0% - 100% [until the [Maternity Care Services] [Tier [2]] Out-of-Pocket Limits are satisfied; [then Tier [X];]

	[X];] [100% thereafter.]]	thereafter.]]	[100% thereafter.]]
[Tier [2]] [Maternity Care Services] [Out-of-Pocket Limit] [each [Calendar Year] [Benefit Period] [Time Period] [Plan Year]] [Individual] [Family]	[$0 - $25,000 / Not applicable] [$0 - $75,000 / Not applicable]	[$0 - $25,000 / Not applicable] [$0 - $75,000 / Not applicable]	[$0 - $25,000 / an additional $0 - $10,000] [$0 - $75,000 / an additional $0 - $30,000]
[Maternity Care Services] [Coinsurance] [Tier [X]]	[0% - 100% [until the [Maternity Care Services] [Tier [X]] Out-of-Pocket Limits are satisfied;] [then Tier [X + [1]];] [100% thereafter.]]	[0% - 100% [until the [Maternity Care Services y] [Tier [X]] Out-of-Pocket Limits are satisfied;] [then Tier [X + [1]];] [100% thereafter.]]	[0% - 100% [until the [Maternity Care Services] [Tier [X]] Out-of-Pocket Limits are satisfied;] [then Tier [X + [1]];] [100% thereafter.]]
[Tier [X]] [Maternity Care Services] [Out-of-Pocket Limit] [each [Calendar Year] [Benefit Period] [Time Period] [Plan Year]] [Individual] [Family]	[$0 - $25,000 / Not applicable] [$0 - $75,000 / Not applicable]	[$0 - $25,000 / Not applicable] [$0 - $75,000 / Not applicable]	[$0 - $25,000 / an additional $0 - $10,000] [$0 - $75,000 / an additional $0 - $30,000]
[[Maternity Care Services] [Out-of-Pocket Limits]] [Individual] [Family]	[$XXX] [$XXX]	[$XXX] [$XXX]	[$XXX] [$XXX]

BEN: 065.001.001.GE

[**Complications of Pregnancy**:]
[All services, supplies and treatments apply to the [Inpatient] [and] [Outpatient] [Calendar Year] [Plan Year] [Benefit Period] [Per Cause] Maximum Benefit]
[Subject to [Plan] [Inpatient] [Outpatient] [Integrated] [Per Cause] Deductible] and [Plan] [Inpatient] [Outpatient] Coinsurance [unless otherwise specified]]
[Benefits are limited to a Maximum [Lifetime] [Calendar Year] [Plan Year] [Monthly] [Daily] [Benefit Period] [Per Cause] Benefit of [$XXX] [per] [Covered Person] [Family]]
[Not Covered]

BEN: 070.001.GE

[**Infertility Services**:]			
[All services, supplies and treatments apply to the [Outpatient] [and] [Calendar Year] [and] [Plan Year] [and] [Benefit Period] [Per Cause] [and] [Monthly] [and] [Daily] Maximum Benefit]			
[Subject to [Plan] [and] [Outpatient] [Integrated] [Per Cause] Deductible] and [Plan] [and] [Outpatient] Coinsurance [unless otherwise specified]]			
[Benefits for Infertility Services are limited to a Maximum [Lifetime] [Calendar Year] [Plan Year] [Monthly] [Daily] [Benefit Period] [Per Cause] Benefit of [$XXX] [per Covered Person]]			
[[Infertility Services] Benefit Waiting Period is [[12] months]] [[365] days]]			
[Not Covered]			
	[[Select] Participating Provider [Benefits]]	**[Participating Provider [Benefits] / Network Provider [Benefits]]**	**[Non-[~~s~~Select] Participating Provider [Benefits]/ Non-participating Provider [Benefits]/ Non-network Provider [Benefits]]**
[[Infertility Services] Maximum [Lifetime] [Calendar Year] [Plan Year] [Benefit Period] [Per Cause] [Monthly] [Daily] Benefit]	[$XXX] [per Covered Person]	[$XXX] [per Covered Person]	[$XXX] [per Covered Person]
[[Infertility Services]l Maximum [Lifetime] [Calendar Year] [Plan Year] [Benefit Period] [Per Cause] [Monthly] [Daily] Benefit] [due to an [Accidental Injury] [or] [underlying Sickness]]	[$XXX] [per Covered Person]	[$XXX] [per Covered Person]	[$XXX] [per Covered Person]
[Benefits for Infertility Services are payable at [0-100%] [with a [$10-$100] copayment] when a Designated Specialty Service Provider is used. If a Designated Specialty Service Provider is not used, [Covered Charges will be [paid at the [Non-][Participating] [or] [applicable] Coinsurance] [reduced by [$1 - $3,000] [1% - 50%]][limited to [$XXX] per [Calendar] [Plan] Year] [per Covered Person] [after the Covered Person has paid any applicable Copayment, Deductible or other fees.] [These limitations will apply to all treatment rendered by a provider that is not designated as a Designated Specialty Service Provider regardless of whether the provider is a [Network Provider,] [Participating Provider,] [or] [Select Participating Provider].]			

BEN: 075.001.001.GE

[**Health Care Practitioner Services**:]
[Subject to [Plan] [Inpatient] [Outpatient] [Integrated] [Per Cause] Deductible] and [Plan] [Inpatient] [Outpatient] Coinsurance [and any other [Plan] [Inpatient] [or] [Outpatient] provision in the Benefit Summary] [unless otherwise specified].]
[Benefits for Covered Charges rendered by an Anesthesiologist are limited to a [Calendar Year] [Plan Year] [Benefit Period] Maximum of [$XXX] for Inpatient services and [$XXX] for Outpatient Services.]

BEN: 080.001.GE

[**Professional Ground [or Air] Ambulance Services**:]			
[All services, supplies and treatments apply to the [Outpatient] [Calendar Year] [Plan Year] [Benefit Period] [Per Cause] Maximum Benefit]			
[Benefits are limited to a[n] [Professional Ground] [or] [Air] Ambulance Services Maximum [Lifetime] [Calendar Year] [Plan Year] [Monthly] [Daily] [Benefit Period] [Per Cause] Benefit of [$XXX] [per] [limited to] [[one] trip] [per Sickness or Injury] [per Covered Person].]			
[Subject to [Plan] [Outpatient] [Integrated] [Per Cause] Deductible] and [Plan] [Outpatient] Coinsurance [unless otherwise specified]]			
[Not Covered]			

	[[Select] Participating Provider [Benefits]]	[Participating Provider [Benefits] / Network Provider [Benefits]]	[Non-[Select] Participating Provider [Benefits]/ Non-Participating Provider [Benefits]/ Non-Network Provider [Benefits]]
[Professional Ground [or Air] Ambulance Services] [Lifetime] [Calendar Year] [Plan Year] [Benefit Period] [Per Cause] Maximum Benefit [per Covered Person]	[$XXX] [and] [or] [limited to] [1] [trip]	[$XXX] [and] [or] [limited to] [1] [trip]	[$XXX] [and] [or] [limited to] [1] [trip]
[Professional Ground [or Air] Ambulance Services] [Coinsurance]	[0% - 100% [until the Out-of-Pocket Limits are satisfied;] [100% thereafter.]]	[0% - 100% [until the Out-of-Pocket Limits are satisfied;] [100% thereafter.]]	[0% - 100% [until the Out-of-Pocket Limits are satisfied;] [100% thereafter.]]

BEN: 085.001.GE

[**Home Health Care Services**:]			
[All services, supplies and treatments apply to the [Outpatient] [Calendar Year] [Plan Year] [Benefit Period] [Per Cause] Maximum Benefit]			
[Subject to [Outpatient] [Plan] [Integrated] [Per Cause] Deductible] and [Outpatient] [Plan] Coinsurance [unless otherwise specified]]			
[Benefits are limited to a Maximum [Calendar Year] [Plan Year] [Benefit Period] [Per Cause] [Monthly] Benefit of [20 - 200~~160~~ hours] [or] [10-100~~40~~ visits][per Covered Person]]			
[Benefits are limited to a Maximum [Lifetime] Benefit of [$XXX] [per] [Covered Person] [Family]]			
[Not Covered]			
	[[Select] Participating Provider [Benefits]]	**[Participating Provider [Benefits] / Network Provider [Benefits]]**	**[Non-[Select] Participating Provider [Benefits]/ Non-Participating Provider [Benefits]/ Non-Network Provider [Benefits]]**
[[Home Health Care Services] Maximum Benefit]	[$XXX]	[$XXX]	[$XXX]
[[Home Health Care Services] [due to an [Accidental Injury] [Injury] [or] [underlying Sickness]	[$XXX]	[$XXX]	[$XXX]
[[Home Health Care Services [Per Cause] Deductible]] [Individual] [Integrated] [Family]	[$XXX] [$XXX]	[$XXX] [$XXX]	[$XXX] [$XXX]
[The [Home Health Care Services Deductible] does [not] apply to the Plan Deductible or Total Out-of-Pocket Limits.]			
[[Non-Participating] [Non-network] Provider Deductible is in addition to the [Participating] [Network] Provider Deductible.]			
[Once [[2] or more Covered Persons have collectively met] the maximum Family Deductible [has been met], no additional Deductible will be taken during the [Calendar Year] [Plan Year] [Benefit Period] [Time Period].]			
[Home Health Care Services] [Coinsurance] [Tier [1]]	[0% - 100% [until the [Home Health Care Services] [Tier [1]] Out-of-Pocket Limits are satisfied; [then Tier [2];] [100% thereafter.]]	[0% - 100% [until the [Home Health Care Services] [Tier [1]] Out-of-Pocket Limits are satisfied; [then Tier [2];] [100%	[0% - 100% [until the [Home Health Care Services] [Tier [1]] Out-of-Pocket Limits are satisfied; [then Tier [2];] [100% thereafter.]]

		thereafter.]]	
[Tier [1]] [Home Health Care Services] [Out-of-Pocket Limit] [each [Calendar Year] [Benefit Period] [Time Period] [Plan Year]] [Individual] [Family]	[$0 - $25,000 / Not applicable] [$0 - $75,000 / Not applicable]	[$0 - $25,000 / Not applicable] [$0 - $75,000 / Not applicable]	[$0 - $25,000 / an additional $0 - $10,000] [$0 - $75,000 / an additional $0 - $30,000]
[Home Health Care Services] [Coinsurance] [Tier [2]]	[0% - 100% [until the [Home Health Care Services] [Tier [2]] Out-of-Pocket Limits are satisfied; [then Tier [X];] [100% thereafter.]]	[0% - 100% [until the [Home Health Care Services] [Tier [2]] Out-of-Pocket Limits are satisfied; [then Tier [X];] [100% thereafter.]]	[0% - 100% [until the [Home Health Care Services] [Tier [2]] Out-of-Pocket Limits are satisfied; [then Tier [X];] [100% thereafter.]]
[Tier [2]] [Home Health Care Services][Out-of-Pocket Limit] [each [Calendar Year] [Benefit Period] [Time Period] [Plan Year]] [Individual] [Family]	[$0 - $25,000 / Not applicable] [$0 - $75,000 / Not applicable]	[$0 - $25,000 / Not applicable] [$0 - $75,000 / Not applicable]	[$0 - $25,000 / an additional $0 - $10,000] [$0 - $75,000 / an additional $0 - $30,000]
[Home Health Care Services] [Coinsurance] [Tier [X]]	[0% - 100% [until the [Home Health Care Services] [Tier [X]] Out-of-Pocket Limits are satisfied;] [then Tier [X + [1]];] [100% thereafter.]]	[0% - 100% [until the [Home Health Care Services] [Tier [X]] Out-of-Pocket Limits are satisfied;] [then Tier [X + [1]];] [100% thereafter.]]	[0% - 100% [until the [Home Health Care Services] [Tier [X]] Out-of-Pocket Limits are satisfied;] [then Tier [X + [1]];] [100% thereafter.]]
[Tier [X]] [Home Health Care Services] [Out-of-Pocket Limit] [each [Calendar Year] [Benefit Period] [Time Period] [Plan Year]] [Individual] [Family]	[$0 - $25,000 / Not applicable] [$0 - $75,000 / Not applicable]	[$0 - $25,000 / Not applicable] [$0 - $75,000 / Not applicable]	[$0 - $25,000 / an additional $0 - $10,000] [$0 - $75,000 / an additional $0 - $30,000]

[[Home Health Care Services] Out-of-Pocket Limits] [Individual] [Integrated] [Family]	[$XXX] [$XXX]	[$XXX] [$XXX]	[$XXX] [$XXX]
[Benefits for Home Health Care Services are payable at [0-100%] [with a [$10-$100] Copayment] when a Designated Specialty Service Provider is used. If a Designated Specialty Service Provider is not used, [Covered Charges will be [paid at the [Non-][Participating] [or] [applicable] Coinsurance] [reduced by [$1 - $3,000] [1% - 50%]][limited to [$XXX] per [Calendar] [Plan] Year] [per Covered Person] [after the Covered Person has paid any applicable Copayment, Deductible or other fees.] [These limitations will apply to all treatment rendered by a provider that is not designated as a Designated Specialty Service Provider regardless of whether the provider is a [Network Provider,] [Participating Provider,] [or] [Select Participating Provider].]			

BEN: 090.001.001.GE

[**Hospice Care Services**:]			
[All services, supplies and treatments apply to the [Outpatient][and] [Inpatient] [Calendar Year] [Plan Year] [Benefit Period] [Per Cause] Maximum Benefit]			
[Subject to [Inpatient] [Outpatient] [Plan] [Integrated] [Per Cause] Deductible] and [Inpatient] [Outpatient] [Plan] Coinsurance [unless otherwise specified].]			
[Benefits are limited to a Maximum [Calendar Year] [Plan Year] [Monthly] [Daily] [Benefit Period] [Per Cause] Benefit of [$XXX] [per] [Covered Person] [Family]]			
[Benefits are limited to a Maximum [Lifetime] Benefit of [$XXX] [per] [Covered Person] [Family]]			
[Hospice Care Services include [2] visits for counseling services and [1] visit for bereavement counseling after a Covered Person's death] [[per] [Covered Person] [Family]]			
[Not Covered]			
	[[Select] Participating Provider [Benefits]]	**[Participating Provider [Benefits] / Network Provider [Benefits]]**	**[Non-[Select] Participating Provider [Benefits]/ Non-Participating Provider [Benefits]/ Non-Network Provider [Benefits]]**
[[Hospice Care Services] Maximum Benefit]	[$XXX]	[$XXX]	[$XXX]
[[Hospice Care Services] Maximum Benefit] [due to an [Accidental Injury] [Injury] [or] [underlying Sickness]	[$XXX]	[$XXX]	[$XXX]
[Hospice Care Services Deductible] [Individual] [Integrated] [Family]	[$XXX] [$XXX]	[$XXX] [$XXX]	[$XXX] [$XXX]
[The [Hospice Care Services Deductible] does [not] apply to the Plan Deductible or Total Out-of-Pocket Limits]			
[[Non-Participating] [Non-network] Provider Deductible is in addition to the [Participating] [Network] Provider Deductible]			
[Once [[2] or more Covered Persons have collectively met] the maximum Family Deductible [has been met], no additional Deductible will be taken during the [Calendar Year] [Plan Year] [Benefit Period] [Time Period].]			
[Hospice Care Services] [Coinsurance] [Tier [1]]	[0% - 100% [until the [Hospice Care Services] [Tier [1]] Out-of-Pocket Limits are satisfied; [then Tier [2];] [100% thereafter.]]	[0% - 100% [until the [Hospice Care Services] [Tier [1]] Out-of-Pocket Limits are satisfied; [then Tier [2];] [100% thereafter.]]	[0% - 100% [until the [Hospice Care Services] [Tier [1]] Out-of-Pocket Limits are satisfied; [then Tier [2];] [100% thereafter.]]

[Tier [1]] [Hospice Care Services] [Out-of-Pocket Limit] [each [Calendar Year] [Benefit Period] [Time Period] [Plan Year]] [Individual] [Family]	[$0 - $25,000 / Not applicable] [$0 - $75,000 / Not applicable]	[$0 - $25,000 / Not applicable] [$0 - $75,000 / Not applicable]	[$0 - $25,000 / an additional $0 - $10,000] [$0 - $75,000 / an additional $0 - $30,000]
[Hospice Care Services] [Coinsurance] [Tier [2]]	[0% - 100% [until the [Hospice Care Services] [Tier [2]] Out-of-Pocket Limits are satisfied; [then Tier [X];] [100% thereafter.]]	[0% - 100% [until the [Hospice Care Services] [Tier [2]] Out-of-Pocket Limits are satisfied; [then Tier [X];] [100% thereafter.]]	[0% - 100% [until the [Hospice Care Services] [Tier [2]] Out-of-Pocket Limits are satisfied; [then Tier [X];] [100% thereafter.]]
[Tier [2]] [Hospice Care Services] [Out-of-Pocket Limit] [each [Calendar Year] [Benefit Period] [Time Period] [Plan Year]] [Individual] [Family]	[$0 - $25,000 / Not applicable] [$0 - $75,000 / Not applicable]	[$0 - $25,000 / Not applicable] [$0 - $75,000 / Not applicable]	[$0 - $25,000 / an additional $0 - $10,000] [$0 - $75,000 / an additional $0 - $30,000]
[Hospice Care Services] [Coinsurance] [Tier [X]]	[0% - 100% [until the [Hospice Care Services] [Tier [X]] Out-of-Pocket Limits are satisfied;] [then Tier [X + [1]];] [100% thereafter.]]	[0% - 100% [until the [Hospice Care Services] [Tier [X]] Out-of-Pocket Limits are satisfied;] [then Tier [X + [1]];] [100% thereafter.]]	[0% - 100% [until the [Hospice Care Services] [Tier [X]] Out-of-Pocket Limits are satisfied;] [then Tier [X + [1]];] [100% thereafter.]]
[Tier [X]] [Hospice Care Services] [Out-of-Pocket Limit] [each [Calendar Year] [Benefit Period] [Time Period] [Plan Year]] [Individual] [Family]	[$0 - $25,000 / Not applicable] [$0 - $75,000 / Not applicable]	[$0 - $25,000 / Not applicable] [$0 - $75,000 / Not applicable]	[$0 - $25,000 / an additional $0 - $10,000] [$0 - $75,000 / an additional $0 - $30,000]
[[Hospice Care Services] Out-of-Pocket Limits] [Individual] [Integrated] [Family]	[$XXX] [$XXX]	[$XXX] [$XXX]	[$XXX] [$XXX]

[Benefits for Hospice Care Service are payable at [0-100%] [with a [$10-$100] Copayment] when a Designated Specialty Service Provider is used. If a Designated Specialty Service Provider is not used, [Covered Charges will be [paid at the [Non-][Participating] [or] [applicable] Coinsurance] [reduced by [$1 - $3,000] [1% - 50%]][limited to [$XXX] per [Calendar] [Plan] Year] [per Covered Person] [after the Covered Person has paid any applicable Copayment, Deductible or other fees.] [These limitations will apply to all treatment rendered by a provider that is not designated as a Designated Specialty Service Provider regardless of whether the provider is a [Network Provider,] [Participating Provider,] [or] [Select Participating Provider].]

BEN: 095.001.001.GE

[**Inpatient Rehabilitation Services**:]

[All services, supplies and treatments apply to the [Inpatient] [and] [Calendar Year] [Plan Year] [Benefit Period] [Per Cause] Maximum Benefit]

[Subject to [Plan] [Inpatient] [Integrated] [Per Cause] Deductible] and [Plan] [Inpatient] Coinsurance [unless otherwise specified]]

[Benefits are limited to a Maximum [Lifetime] [Calendar Year] [Plan Year] [Benefit Period] [Per Cause] [Monthly] [Daily] Benefit of [$XXX] [or] [90 days] [per Covered Person] [whichever is less] [greater]]

[Not Covered]

	[[Select] Participating Provider [Benefits]]	**[Participating Provider [Benefits] / Network Provider [Benefits]]**	**[Non-[Select} Participating Provider [Benefits]/ Non-Participating Provider [Benefits]/ Non-Network Provider [Benefits]]**
[[Inpatient Rehabilitation Services] Maximum [Lifetime] [Calendar Year] [Plan Year] [Benefit Period] [Per Cause] [Monthly] [Daily] Benefit	[$XXX] [or] [90][days] [per Covered Person] [whichever is [less] [greater]]	[$XXX] [or] [90][days] [per Covered Person] [whichever is [less] [greater]]	[$XXX] [or] [90][days] [per Covered Person] [whichever is [less] [greater]]
[Inpatient Rehabilitation Services [Per Cause] Deductible] [Individual]	[$XXX]	[$XXX]	[$XXX]
[Integrated] [Family]	[$XXX]	[$XXX]	[$XXX]
[The [Inpatient Rehabilitation Services Deductible] does [not] apply to the Plan Deductible or Total Out-of-Pocket Limits.]			
[[Non-Participating] [Non-network] Provider Deductible is in addition to the [Participating] [Network] Provider Deductible.]			
[Once [[2] or more Covered Persons have collectively met] the maximum Family Deductible [has been met], no additional Deductible will be taken during the [Calendar Year] [Plan Year] [Benefit Period] [Time Period].]			
[Inpatient Rehabilitation Services] [Coinsurance] [Tier [1]]	[0% - 100% [until the [Inpatient Rehabilitation Services] [Tier [1]] Out-of-Pocket Limits are satisfied; [then Tier [2];] [100% thereafter.]]	[0% - 100% [until the [Inpatient Rehabilitation Services] [Tier [1]] Out-of-Pocket Limits are satisfied; [then Tier [2];] [100% thereafter.]]	[0% - 100% [until the [Inpatient Rehabilitation Services] [Tier [1]] Out-of-Pocket Limits are satisfied; [then Tier [2];] [100% thereafter.]]
[Tier [1]] [Inpatient Rehabilitation Services] [Out-of-Pocket Limit] [each [Calendar Year] [Benefit Period] [Time Period] [Plan Year]] [Individual]	[$0 - $25,000 / Not applicable]	[$0 - $25,000 / Not applicable]	[$0 - $25,000 / an additional

[Family]	[$0 - $75,000 / Not applicable]	[$0 - $75,000 / Not applicable]	$0 - $10,000] [$0 - $75,000 / an additional $0 - $30,000]
[Inpatient Rehabilitation Services] [Coinsurance] [Tier [2]]	[0% - 100% [until the [Inpatient Rehabilitation Services] [Tier [2]] Out-of-Pocket Limits are satisfied; [then Tier [X];] [100% thereafter.]]	[0% - 100% [until the [Inpatient Rehabilitation Services] [Tier [2]] Out-of-Pocket Limits are satisfied; [then Tier [X];] [100% thereafter.]]	[0% - 100% [until the [Inpatient Rehabilitation Services] [Tier [2]] Out-of-Pocket Limits are satisfied; [then Tier [X];] [100% thereafter.]]
[Tier [2]] [Inpatient Rehabilitation Services] [Out-of-Pocket Limit] [each [Calendar Year] [Benefit Period] [Time Period] [Plan Year]] [Individual]	[$0 - $25,000 / Not applicable]	[$0 - $25,000 / Not applicable]	[$0 - $25,000 / an additional $0 - $10,000]
[Family]	[$0 - $75,000 / Not applicable]	[$0 - $75,000 / Not applicable]	[$0 - $75,000 / an additional $0 - $30,000]
[Inpatient Rehabilitation Services] [Coinsurance] [Tier [X]]	[0% - 100% [until the [Inpatient Rehabilitation Services] [Tier [X]] Out-of-Pocket Limits are satisfied;] [then Tier [X + [1]];] [100% thereafter.]]	[0% - 100% [until the [Inpatient Rehabilitation Services] [Tier [X]] Out-of-Pocket Limits are satisfied;] [then Tier [X + [1]];] [100% thereafter.]]	[0% - 100% [until the [Inpatient Rehabilitation Services] [Tier [X]] Out-of-Pocket Limits are satisfied;] [then Tier [X + [1]];] [100% thereafter.]]
[Tier [X]] [Inpatient Rehabilitation Services] [Out-of-Pocket Limit] [each [Calendar Year] [Benefit Period] [Time Period] [Plan Year]] [Individual]	[$0 - $25,000 / Not applicable]	[$0 - $25,000 / Not applicable]	[$0 - $25,000 / an additional $0 - $10,000]
[Family]	[$0 - $75,000 / Not applicable]	[$0 - $75,000 / Not applicable]	[$0 - $75,000 / an additional $0 - $30,000]
[[Inpatient Rehabilitation Services] [Out-of-Pocket Limits]] [Individual]	[$XXX]	[$XXX]	[$XXX]
[Integrated] [Family]	[$XXX]	[$XXX]	[$XXX]
[Benefits for Inpatient Rehabilitation Services are payable at [0-100%] [with a [$10-$100] Copayment] when a Designated Specialty Service Provider is used. If a [Designated Specialty Service Provider] is not used, [Covered Charges will be [paid at the [Non-][Participating] [or] [applicable] Coinsurance] [reduced by [$1 - $3,000] [1% -			

50%]][limited to [$XXX] per [Calendar] [Plan] Year] [per Covered Person] [after the Covered Person has paid any applicable Copayment, Deductible or other fees.] [These limitations will apply to all treatment rendered by a provider that is not designated as a Designated Specialty Service Provider regardless of whether the provider is a [Network Provider,] [Participating Provider,] [or] [Select Participating Provider].]

BEN: 100.001.GE

[[**Subacute Rehabilitation Facility**] [**and/or**] [**Skilled Nursing Facility Care**]:]			
[All services, supplies and treatments apply to the [Outpatient] [and] [Inpatient] [Calendar Year] [Plan Year] [Benefit Period] [Per Cause] Maximum Benefit]			
[Subject to [Outpatient] [and] [Inpatient] [Calendar Year] [Plan Year] [Benefit Period] [Per Cause] [Plan] [Integrated] [Per Cause] Deductible] [and][Outpatient] [and] [Inpatient] [Calendar Year] [Plan Year] [Benefit Period] [Per Cause] [Plan] Coinsurance [unless otherwise specified]]			
[Benefits are limited to a Maximum [Lifetime] [Calendar Year] [Plan Year] [Benefit Period] [Per Cause] [Monthly] [Daily] Benefit of [$XXX] [or] [90 days] [per Covered Person] [whichever is [less] [greater].]			
[Benefits are limited to a Maximum of [$XXX] per day, up to [50] Days per [Calendar Year] [Plan Year] [Benefit Period] [Per Cause] [per Covered Person]]			
[Not Covered]			
	[[Select] Participating Provider [Benefits]]	**[Participating Provider [Benefits] / Network Provider [Benefits]]**	**[Non-[Select] Participating Provider [Benefits]/ Non-Participating Provider [Benefits]/ Non-Network Provider [Benefits]]**
[[Subacute Rehabilitation Facility and Skilled Nursing Facility Care] Maximum Benefit]	[$XXX]	[$XXX]	[$XXX]
[[Subacute Rehabilitation Facility and Skilled Nursing Facility Care] [due to an [Accidental Injury] [Injury] [or] [underlying Sickness]]	[$XXX]	[$XXX]	[$XXX]
[Subacute Rehabilitation Facility and Skilled Nursing Facility Care [Per Cause] Deductible] [Individual] [Integrated] [Family]	 [$XXX] [$XXX]	 [$XXX] [$XXX]	 [$XXX] [$XXX]
[The [Subacute Rehabilitation Facility and Skilled Nursing Facility Care Deductible] does [not] apply to the Plan Deductible or Total Out-of-Pocket Limits.]			
[[Non-Participating] [Non-network] Provider Deductible is in addition to the [Participating] [Network] Provider Deductible.]			
[Once [[2] or more Covered Persons have collectively met] the maximum Family Deductible [has been met], no additional Deductible will be taken during the [Calendar Year] [Plan Year] [Benefit Period] [Time Period].]			
[Subacute Rehabilitation Facility and Skilled Nursing Facility Care] [Coinsurance] [Tier [1]]	[0% - 100% [until the [Subacute Rehabilitation Facility and Skilled Nursing Facility Care] [Tier [1]] Out-of-Pocket Limits are satisfied; [then Tier [2];] [100% thereafter.]]	[0% - 100% [until the [Subacute Rehabilitation Facility and Skilled Nursing Facility Care] [Tier [1]] Out-of-Pocket Limits are satisfied; [then Tier [2];] [100% thereafter.]]	[0% - 100% [until the [Subacute Rehabilitation Facility and Skilled Nursing Facility Care] [Tier [1]] Out-of-Pocket Limits are satisfied; [then Tier [2];] [100% thereafter.]]

[Tier [1]] [Subacute Rehabilitation Facility and Skilled Nursing Facility Care] [Out-of-Pocket Limit] [each [Calendar Year] [Benefit Period] [Time Period] [Plan Year]] [Individual] [Family]	[$0 - $25,000 / Not applicable] [$0 - $75,000 / Not applicable]	[$0 - $25,000 / Not applicable] [$0 - $75,000 / Not applicable]	[$0 - $25,000 / an additional $0 - $10,000] [$0 - $75,000 / an additional $0 - $30,000]
[Subacute Rehabilitation Facility and Skilled Nursing Facility Care] [Coinsurance] [Tier [2]]	[0% - 100% [until the [Subacute Rehabilitation Facility and Skilled Nursing Facility Care] [Tier [2]] Out-of-Pocket Limits are satisfied; [then Tier [X];] [100% thereafter.]]	[0% - 100% [until the [Subacute Rehabilitation Facility and Skilled Nursing Facility Care] [Tier [2]] Out-of-Pocket Limits are satisfied; [then Tier [X];] [100% thereafter.]]	[0% - 100% [until the [Subacute Rehabilitation Facility and Skilled Nursing Facility Care] [Tier [2]] Out-of-Pocket Limits are satisfied; [then Tier [X];] [100% thereafter.]]
[Tier [2]] [Subacute Rehabilitation Facility and Skilled Nursing Facility Care] [Out-of-Pocket Limit] [each [Calendar Year] [Benefit Period] [Time Period] [Plan Year]] [Individual] [Family]	[$0 - $25,000 / Not applicable] [$0 - $75,000 / Not applicable]	[$0 - $25,000 / Not applicable] [$0 - $75,000 / Not applicable]	[$0 - $25,000 / an additional $0 - $10,000] [$0 - $75,000 / an additional $0 - $30,000]
[Subacute Rehabilitation Facility and Skilled Nursing Facility Care] [Coinsurance] [Tier [X]]	[0% - 100% [until the [Subacute Rehabilitation Facility and Skilled Nursing Facility Care] [Tier [X]] Out-of-Pocket Limits are satisfied;] [then Tier [X + [1]];] [100% thereafter.]]	[0% - 100% [until the [Subacute Rehabilitation Facility and Skilled Nursing Facility Care] [Tier [X]] Out-of-Pocket Limits are satisfied;] [then Tier [X + [1]];] [100% thereafter.]]	[0% - 100% [until the [Subacute Rehabilitation Facility and Skilled Nursing Facility Care] [Tier [X]] Out-of-Pocket Limits are satisfied;] [then Tier [X + [1]];] [100% thereafter.]]
[Tier [X]] [Subacute Rehabilitation Facility and Skilled Nursing Facility Care] [Out-of-Pocket Limit] [each [Calendar Year] [Benefit Period] [Time Period] [Plan Year]] [Individual] [Family]	[$0 - $25,000 / Not applicable] [$0 - $75,000 / Not applicable]	[$0 - $25,000 / Not applicable] [$0 - $75,000 / Not applicable]	[$0 - $25,000 / an additional $0 - $10,000] [$0 - $75,000 / an additional

			$0 - $30,000]
[[Subacute Rehabilitation Facility and Skilled Nursing Facility Care] [Out-of-Pocket Limits]] [Individual] [Family]	 [$XXX] [$XXX]	 [$XXX] [$XXX]	 [$XXX] [$XXX]
[Benefits for Subacute Rehabilitation Facility and Skilled Nursing Facility Care are payable at [0-100%] [with a [$10-$100] Copayment] when a Designated Specialty Service Provider is used. If a Designated Specialty Service Provider is not used, [Covered Charges will be [paid at the [Non-][Participating] [or] [applicable] Coinsurance] [reduced by [$1 - $3,000] [1% - 50%]][limited to [$XXX] per [Calendar] [Plan] Year] [per Covered Person] [after the Covered Person has paid any applicable Copayment, Deductible or other fees.] [These limitations will apply to all treatment rendered by a provider that is not designated as a Designated Specialty Service Provider regardless of whether the provider is a [Network Provider,] [Participating Provider,] [or] [Select Participating Provider].]			

BEN: 105.001.GE

[**Family Planning Services**:]			
[All services, supplies and treatments apply to the [Outpatient] [and] [Calendar Year] [and] [Plan Year] [and] [Benefit Period] [Per Cause] [and] [Monthly] [and] [Daily] Maximum Benefit]			
[Subject to [Plan] [and] [Outpatient] [Integrated] Deductible and [Plan] [and] [Outpatient] Coinsurance [unless otherwise specified]]			
[Benefits for Family Planning Services are limited to a Maximum [Lifetime] [Calendar Year] [Plan Year] [Monthly] [Daily] [Benefit Period] [Per Cause] Benefit of [$XXX] [per Covered Person]]			
[[Family Planning Services] Benefit Waiting Period is [[12] months]] [[365] days]]			
[Not Covered]			
	[[Select] Participating Provider [Benefits]]	**[Participating Provider [Benefits] / Network Provider [Benefits]]**	**[Non-[Select] Participating Provider [Benefits]/ Non-Participating Provider [Benefits]/ Non-Network Provider [Benefits]]**
[[Family Planning Services] Maximum [Lifetime] [Calendar Year] [Plan Year] [Benefit Period] [Per Cause] [Monthly] [Daily] Benefit]	[$XXX] [per Covered Person]	[$XXX] [per Covered Person]	[$XXX] [per Covered Person]
[[Family Planning Services]l Maximum [Lifetime] [Calendar Year] [Plan Year] [Benefit Period] [Per Cause] [Monthly] [Daily] Benefit] [due to an [Accidental Injury] [Injury] [or] [underlying Sickness]	[$XXX] [per Covered Person]	[$XXX] [per Covered Person]	[$XXX] [per Covered Person]
[Benefits for Family Planning Services are payable at [0-100%] [with a [$10-$100] Copayment] when a Designated Specialty Service Provider is used. If a Designated Specialty Service Provider is not used, [Covered Charges will be [paid at the [Non-][Participating] [or] [applicable] Coinsurance] [reduced by [$1 - $3,000] [1% - 50%]][limited to [$XXX] per [Calendar] [Plan] Year] [per Covered Person] [after the Covered Person has paid any applicable Copayment, Deductible or other fees.] [These limitations will apply to all treatment rendered by a provider that is not designated as a Designated Specialty Service Provider regardless of whether the provider is a [Network Provider,] [Participating Provider,] [or] [Select Participating Provider].]			

[**Sterilization**:]			
[All services, supplies and treatments apply to the [Outpatient] [Calendar Year] [Plan Year] [Benefit Period] [Per Cause] Maximum Benefit]			
[Subject to [Plan] [Outpatient] [Integrated] [Per Cause] Deductible] and Coinsurance [unless otherwise specified].]			
[Benefits for Sterilization Services are limited to a Maximum [Lifetime] [Calendar Year] [Plan Year] [Benefit Period] [Per Cause] [Monthly] [Daily] Benefit of [$250 - $2,500~~$500~~] [per Covered Person].]			
[Sterilization Services Benefit Waiting Period is [[12] months] [[365] days]].			
[Not Covered]			
	[[Select] Participating Provider [Benefits]]	**[Participating Provider [Benefits] / Network Provider [Benefits]]**	**[Non-[Select] Participating Provider [Benefits]/ Non-Participating Provider [Benefits]/ Non-Network Provider [Benefits]]**
[[Sterilization Services] Maximum [Lifetime] [Calendar Year] [Plan Year] [Benefit Period] [Per Cause] [Monthly] [Daily] Benefit]	[$XXX] [per Covered Person]	[$XXX] [per Covered Person]	[$XXX] [per Covered Person]
[Benefits for [Sterilization Services] are payable at [0-100%] [with a [$10-$100] Copayment] when a [Designated Specialty Service Provider] is used. If a [Designated Specialty Service Provider] is not used, [Covered Charges will be [paid at the [Non-][Participating] [or] [applicable] Coinsurance] [reduced by [$1 - $3,000] [1% - 50%]][limited to [$XXX] per [Calendar] [Plan] Year] [per Covered Person] [after the Covered Person has paid any applicable Copayment, Deductible or other fees.] [These limitations will apply to all treatment rendered by a provider that is not designated as a [Designated Specialty Service Provider] regardless of whether the provider is a [Network Provider,] [Participating Provider,] [or] [Select Participating Provider].]			

BEN: 115.001.001.GE

[**Temporomandibular Joint (TMJ) or Craniomandibular Joint (CMJ) Dysfunction Services**:]			
[All services, supplies and treatments apply to the [Outpatient] [Calendar Year] [Plan Year] [Benefit Period] [Per Cause] Maximum Benefit]			
[Subject to [Plan] [Outpatient] [Integrated] Deductible and [Plan] [Outpatient] Coinsurance [unless otherwise specified]]			
[Benefits for [surgical and] nonsurgical treatment are limited to a Maximum [Lifetime] [Calendar Year] [Plan Year] [Monthly] [Daily] [Benefit Period] [Per Cause] Benefit of [$XXX] [per] [Covered Person] [Family]]			
[Temporomandibular Joint (TMJ) or Craniomandibular Joint (CMJ) Dysfunction Services Benefit Waiting Period is [[12] months] [[365] days].]			
[Not Covered]			
	[[Select] Participating Provider [Benefits]]	**[Participating Provider [Benefits] / Network Provider [Benefits]]**	**[Non-[Select] Participating Provider [Benefits]/ Non-Participating Provider [Benefits]/ Non-Network Provider [Benefits]]**
[[Temporomandibular Joint (TMJ) or Craniomandibular Joint (CMJ) Dysfunction Services] [surgical and] non-surgical Maximum [Lifetime] [Calendar Year] [Plan Year] [Benefit Period] [Per Cause] [Monthly] [Daily] Benefit]	[$XXX] [per Covered Person] [per Family]	[$XXX] [per Covered Person] [per Family]	[$XXX] [per Covered Person] [per Family]

[[Temporomandibular Joint (TMJ) or Craniomandibular Joint (CMJ) Dysfunction Services] surgical and] non-surgical Maximum [Lifetime] [Calendar Year] [Plan Year] [Benefit Period] [Per Cause] [Monthly] [Daily] Benefit] [due to an [Accidental Injury] [Injury] [or] [underlying Sickness]	[$XXX] [per Covered Person] [per Family]	[$XXX] [per Covered Person] [per Family]	[$XXX] [per Covered Person] [per Family]
[Temporomandibular Joint (TMJ) or Craniomandibular Joint (CMJ) Dysfunction Services Deductible] [Individual] [Integrated] [Family]	[$XXX] [$XXX]	[$XXX] [$XXX]	[$XXX] [$XXX]
[The [Temporomandibular Joint (TMJ) or Craniomandibular Joint (CMJ) Dysfunction Services Deductible] does [not] apply to the [Plan][Outpatient] [Integrated] [Per Cause] Deductible] or Total Out-of-Pocket Limits.]			
[[Non-Participating] [Non-network] Provider Deductible is in addition to the [Participating] [Network] Provider Deductible.]			
[Once [[2] or more Covered Persons have collectively met] the maximum Family Deductible [has been met], no additional Deductible will be taken during the [Calendar Year] [Plan Year] [Benefit Period] [Time Period].]			
[Temporomandibular Joint (TMJ) or Craniomandibular Joint (CMJ) Dysfunction Services] [Coinsurance] [Tier [1]]	[0% - 100% [until the [Temporomandibular Joint (TMJ) or Craniomandibular Joint (CMJ) Dysfunction Services] [Tier [1]] Out-of-Pocket Limits are satisfied; [then Tier [2];] [100% thereafter.]]	[0% - 100% [until the [Temporomandibular Joint (TMJ) or Craniomandibular Joint (CMJ) Dysfunction Services] [Tier [1]] Out-of-Pocket Limits are satisfied; [then Tier [2];] [100% thereafter.]]	[0% - 100% [until the [Temporomandibular Joint (TMJ) or Craniomandibular Joint (CMJ) Dysfunction Services] [Tier [1]] Out-of-Pocket Limits are satisfied; [then Tier [2];] [100% thereafter.]]
[Tier [1]] [Temporomandibular Joint (TMJ) or Craniomandibular Joint (CMJ) Dysfunction Services] [Out-of-Pocket Limit] [each [Calendar Year] [Benefit Period] [Time Period] [Plan Year]] [Individual] [Family]	[$0 - $25,000 / Not applicable] [$0 - $75,000 / Not applicable]	[$0 - $25,000 / Not applicable] [$0 - $75,000 / Not applicable]	[$0 - $25,000 / an additional $0 - $10,000] [$0 - $75,000 / an additional $0 - $30,000]
[Temporomandibular Joint (TMJ) or Craniomandibular Joint (CMJ) Dysfunction Services] [Coinsurance] [Tier [2]]	[0% - 100% [until the [Temporomandibular Joint (TMJ) or Craniomandibular Joint (CMJ) Dysfunction Services] [Tier [2]] Out-of-Pocket Limits are satisfied; [then Tier [X];] [100% thereafter.]]	[0% - 100% [until the [Temporomandibular Joint (TMJ) or Craniomandibular Joint (CMJ) Dysfunction Services] [Tier [2]] Out-of-Pocket Limits are satisfied; [then Tier [X];] [100% thereafter.]]	[0% - 100% [until the [Temporomandibular Joint (TMJ) or Craniomandibular Joint (CMJ) Dysfunction Services] [Tier [2]] Out-of-Pocket Limits are satisfied; [then Tier [X];] [100% thereafter.]]

[Tier [2]] [Temporomandibular Joint (TMJ) or Craniomandibular Joint (CMJ) Dysfunction Services] [Out-of-Pocket Limit][each [Calendar Year] [Benefit Period] [Time Period] [Plan Year]] [Individual] [Family]	 [$0 - $25,000 / Not applicable] [$0 - $75,000 / Not applicable]	 [$0 - $25,000 / Not applicable] [$0 - $75,000 / Not applicable]	 [$0 - $25,000 / an additional $0 - $10,000] [$0 - $75,000 / an additional $0 - $30,000]
[Temporomandibular Joint (TMJ) or Craniomandibular Joint (CMJ) Dysfunction Services] [Coinsurance] [Tier [X]]	[0% - 100% [until the [Temporomandibular Joint (TMJ) or Craniomandibular Joint (CMJ) Dysfunction Services] [Tier [X]] Out-of-Pocket Limits are satisfied;] [then Tier [X + [1]];] [100% thereafter.]]	[0% - 100% [until the [Temporomandibular Joint (TMJ) or Craniomandibular Joint (CMJ) Dysfunction Services] [Tier [X]] Out-of-Pocket Limits are satisfied;] [then Tier [X + [1]];] [100% thereafter.]]	[0% - 100% [until the [Temporomandibular Joint (TMJ) or Craniomandibular Joint (CMJ) Dysfunction Services] [Tier [X]] Out-of-Pocket Limits are satisfied;] [then Tier [X + [1]];] [100% thereafter.]]
[Tier [X]] [Temporomandibular Joint (TMJ) or Craniomandibular Joint (CMJ) Dysfunction Services][Out-of-Pocket Limit][each [Calendar Year] [Benefit Period] [Time Period] [Plan Year]] [Individual] [Family]	 [$0 - $25,000 / Not applicable] [$0 - $75,000 / Not applicable]	 [$0 - $25,000 / Not applicable] [$0 - $75,000 / Not applicable]	 [$0 - $25,000 / an additional $0 - $10,000] [$0 - $75,000 / an additional $0 - $30,000]
[[Temporomandibular Joint (TMJ) or Craniomandibular Joint (CMJ) Dysfunction Services] [Out-of-Pocket Limits]] [Individual] [Family]	 [$XXX] [$XXX]	 [$XXX] [$XXX]	 [$XXX] [$XXX]

BEN: 120.001.001.GE

[**Diabetic Services**:]
[All services, supplies and treatments apply to the [Outpatient] [and] [Calendar Year] [and] [Plan Year] [Benefit Period] [Per Cause] Maximum Benefit]
[Subject to [Plan] [and] [Outpatient] [Integrated] [Per Cause] Deductible] and [Plan] [and] [Outpatient] Coinsurance [unless otherwise specified]]
[Covered Charges include: • [Eye Examinations: [Both eyes] [1] per [Calendar Year] [Plan Year] [per Covered Person]] • [Foot Examination: [Both feet] [1] per [Calendar Year] [Plan Year] [per Covered Person]]

• [Nutritional Counseling: [When first diagnosed] [or] [and] [when changes in condition occur] [per Covered Person]]]
[Not Covered]

	[[Select] Participating Provider [Benefits]]	**[Participating Provider [Benefits] / Network Provider [Benefits]]**	**[Non-[Select] Participating Provider [Benefits]/ Non-Participating Provider [Benefits]/ Non-Network Provider [Benefits]]**
[[Diabetic Services] Maximum [Lifetime] [Calendar Year] [Plan Year] [Benefit Period] [Per Cause] [Monthly] [Daily] Benefit]	[$XXX] [per Covered Person]	[$XXX] [per Covered Person]	[$XXX] [per Covered Person]
[[Diabetic Services]l Maximum [Lifetime] [Calendar Year] [Plan Year] [Benefit Period] [Per Cause] [Monthly] [Daily] Benefit] [due to an [Accidental Injury] [Injury] [or] [underlying Sickness]	[$XXX] [per Covered Person]	[$XXX] [per Covered Person]	[$XXX] [per Covered Person]
[Benefits for Diabetic Services are payable at [0-100%] [with a [$10-$100] Copayment] when a Designated Specialty Service Provider is used. If a Designated Specialty Service Provider is not used, [Covered Charges will be [paid at the [Non-][Participating] [or] [applicable] Coinsurance] [reduced by [$1 - $3,000] [1% - 50%]][limited to [$XXX] per [Calendar] [Plan] Year] [per Covered Person] [after the Covered Person has paid any applicable Copayment, Deductible or other fees.] [These limitations will apply to all treatment rendered by a provider that is not designated as a Designated Specialty Service Provider regardless of whether the provider is a [Network Provider,] [Participating Provider,] [or] [Select Participating Provider].]			

BEN: 125.001.001.GE

[**Growth Hormone Therapy Services**:]
[All services, supplies and treatments apply to the [Outpatient] [Calendar Year] [Plan Year] [Benefit Period] [Per Cause] Maximum Benefit]
[Subject to [Plan] [Outpatient] [Integrated] [Per Cause] Deductible] and [Plan] [Outpatient] Coinsurance [unless otherwise specified]]
[Benefits for Growth Hormone Therapy Services are limited to a Maximum [Lifetime] [Calendar Year] [Plan Year] [Monthly] [Daily] [Benefit Period] [Per Cause] Benefit of [$XXX]] [per Covered Person].]
[Growth Hormone Therapy Services Benefit Waiting Period is [[12] months] [[365] days]]
[Not Covered]

	[[Select] Participating Provider [Benefits]]	**[Participating Provider [Benefits] / Network Provider [Benefits]]**	**[Non-[Select] Participating Provider [Benefits]/ Non-Participating Provider [Benefits]/ Non-Network Provider [Benefits]]**
[[Growth Hormone Therapy Services] Maximum [Lifetime] [Calendar Year] [Plan Year] [Benefit Period] [Per Cause] [Monthly] [Daily] Benefit]	[$XXX] [per Covered Person]	[$XXX] [per Covered Person]	[$XXX] [per Covered Person]

BEN: 130.001.001.GE

[**Tonsils and Adenoids**:]
[All services, supplies and treatments apply to the [Outpatient] [and] [Calendar Year] [and] [Plan Year] [Benefit Period] [Per Cause] Maximum Benefit]

[Subject to [Plan] [and] [Outpatient] [Integrated] [Per Cause] Deductible] and [Plan] [and] [Outpatient] Coinsurance [unless otherwise specified].]			
[Benefits for Tonsils and Adenoids Services are limited to a Maximum [Lifetime] [Calendar Year] [Plan Year] [Benefit Period] [Per Cause] [Monthly] [Daily] Benefit of [$500 - $2,000~~$1,000~~] [per Covered Person]]			
[[Tonsils and Adenoids Services] Benefit Waiting Period is [[12] months] [[365] days].]			
[Not Covered]			
	[[Select] Participating Provider [Benefits]]	**[Participating Provider [Benefits] / Network Provider [Benefits]]**	**[Non-[Select] Participating Provider [Benefits]/ Non-Participating Provider [Benefits]/ Non-Network Provider [Benefits]]**
[[Tonsils and Adenoids Services] Maximum [Lifetime] [Calendar Year] [Plan Year] [Benefit Period] [Per Cause] [Monthly] [Daily] Benefit]	[$XXX] [per Covered Person]	[$XXX] [per Covered Person]	[$XXX] [per Covered Person]
[Benefits for Tonsils and Adenoids Services are payable at [0-100%] [with a [$10-$100] Copayment] when a Designated Specialty Service Provider is used. If a Designated Specialty Service Provider is not used, [Covered Charges will be [paid at the [Non-][Participating] [or] [applicable] Coinsurance] [reduced by [$1 - $3,000] [1% - 50%]][limited to [$XXX] per [Calendar] [Plan] Year] [per Covered Person] [after the Covered Person has paid any applicable Copayment, Deductible or other fees.] [These limitations will apply to all treatment rendered by a provider that is not designated as a Designated Specialty Service Provider regardless of whether the provider is a [Network Provider,] [Participating Provider,] [or] [Select Participating Provider].]			

BEN: 135.001.001.GE

[**Bunions,**] [**Hemorrhoids**] [**and**] [**Varicose Veins**]:			
[All services, supplies and treatments apply to the [Outpatient] [Calendar Year] [Plan Year] [Benefit Period] [Per Cause] Maximum Benefit]			
[Subject to [Plan] [Inpatient] [Outpatient] [Integrated] [Per Cause] Deductible] and Coinsurance [unless otherwise specified].]			
[Benefits for [Bunions,] [Hemorrhoids] [and] [Varicose Veins] Services are limited to a Maximum [Lifetime] [Calendar Year] [Plan Year] [Benefit Period] [Per Cause] [Monthly] [Daily] Benefit of [$500 - $2,000~~$500~~] [per Covered Person]			
[Benefits for [Bunions,] [Hemorrhoids] [and] [Varicose Veins] Services Benefit Waiting Period is [[12] months] [[365] days].]			
[Not Covered]			
	[[Select] Participating Provider [Benefits]]	**[Participating Provider [Benefits] / Network Provider [Benefits]]**	**[Non-[Select] Participating Provider [Benefits]/ Non-Participating Provider [Benefits]/ Non-Network Provider [Benefits]]**
[[Bunions,] [Hemorrhoids] [and] [Varicose Veins]Services] Maximum [Lifetime] [Calendar Year] [Plan Year] [Benefit Period] [Per Cause] [Monthly] [Daily] Benefit]	[$XXX] [per Covered Person]	[$XXX] [per Covered Person]	[$XXX] [per Covered Person]
[Benefits for [Bunions,] [Hemorrhoids] [and] [Varicose Veins] Services are payable at [0-100%] [with a [$10-$100] Copayment] when a Designated Specialty Service Provider is used. If a [Designated Specialty Service Provider] is not used, [Covered Charges will be [paid at the [Non-][Participating] [or] [applicable] Coinsurance] [reduced by [$1 - $3,000] [1% - 50%]][limited to [$XXX] per [Calendar] [Plan] Year] [per Covered Person] [after the Covered Person has paid any applicable Copayment, Deductible or other fees.] [These limitations will apply to all treatment rendered by			

a provider that is not designated as a Designated Specialty Service Provider regardless of whether the provider is a [Network Provider,] [Participating Provider,] [or] [Select Participating Provider].]

BEN: 140.001.001.GE

[**Inguinal Hernia**:]			
[All services, supplies and treatments apply to the [Outpatient] [and] [Calendar Year] [and] [Plan Year] [Benefit Period] [Per Cause] Maximum Benefit]			
[Subject to [Plan] [Inpatient] [and] [Outpatient] [Integrated] [Per Cause] Deductible] and [Plan] [Inpatient] [and] [Outpatient] Coinsurance [unless otherwise specified].]			
[Benefits for Inguinal Hernia Services are limited to a Maximum [Lifetime] [Calendar Year] [Plan Year] [Benefit Period] [Per Cause] [Monthly] [Daily] Benefit of [$250 - $2,000~~$500~~] [per Covered Person].]			
[Inguinal Hernia Services Benefit Waiting Period is [[12] months] [[365] days].]			
[Not Covered]			
	[[Select] Participating Provider [Benefits]]	**[Participating Provider [Benefits] / Network Provider [Benefits]]**	**[Non-[Select] Participating Provider [Benefits]/ Non-Participating Provider [Benefits]/ Non-Network Provider [Benefits]]**
[[Inguinal Hernia]Services] Maximum [Lifetime] [Calendar Year] [Plan Year] [Benefit Period] [Per Cause] [Monthly] [Daily] Benefit]	[$XXX] [per Covered Person]	[$XXX] [per Covered Person]	[$XXX] [per Covered Person]
[Benefits for Inguinal Hernia Services are payable at [0-100%] [with a [$10-$100] Copayment] when a Designated Specialty Service Provider is used. If a Designated Specialty Service Provider is not used, [Covered Charges will be [paid at the [Non-][Participating] [or] [applicable] Coinsurance] [reduced by [$1 - $3,000] [1% - 50%]][limited to [$XXX] per [Calendar] [Plan] Year] [per Covered Person] [after the Covered Person has paid any applicable Copayment, Deductible or other fees.] [These limitations will apply to all treatment rendered by a provider that is not designated as a Designated Specialty Service Provider regardless of whether the provider is a [Network Provider,] [Participating Provider,] [or] [Select Participating Provider].]			

BEN: 145.001.001.GE

[**Blood Product Transfusions**:]			
[All services, supplies and treatments apply to the [Outpatient] [and] [Calendar Year] [Plan Year] [Benefit Period] [and] [Per Cause] Maximum Benefit]			
[Subject to[Integrated] [Plan][Inpatient][and] [Outpatient] [Per Cause] Deductible] and [Plan][Inpatient][and] [Outpatient] [and] Coinsurance [unless otherwise specified]]			
	[[Select] Participating Provider [Benefits]]	**[Participating Provider [Benefits] / Network Provider [Benefits]]**	**[Non-[Select] Participating Provider [Benefits]/ Non-Participating Provider [Benefits]/ Non-Network Provider [Benefits]]**
[Blood Product Transfusions Maximum [Lifetime] [Calendar Year] [Plan Year] [Benefit Period] [Per Cause] [Monthly] [Daily] Benefit]	[$XXX] [per Covered Person]	[$XXX] [per Covered Person]	[$XXX] [per Covered Person]
[Blood Product Transfusions Deductible] [Individual] [Integrated] [Family]	 [$XXX] [$XXX]	 [$XXX] [$XXX]	 [$XXX] [$XXX]

[The [Blood Product Transfusions Deductible] does [not] apply to the Plan Deductible or Total Out-of-Pocket Limits.]			
[[Non-Participating] [Non-network] Provider Deductible is in addition to the [Participating] [Network] Provider Deductible.]			
[Once [[2] or more Covered Persons have collectively met] the maximum Family Deductible [has been met], no additional Deductible will be taken during the [Calendar Year] [Plan Year] [Benefit Period] [Time Period].]			
[Access] [Fee]	[None / $XXX per Blood Product Transfusions]	[None / $XXX per Blood Product Transfusions]	[None / $XXX per Blood Product Transfusions]
[Copayment]	[None / $XXX per Blood Product Transfusions]	[None / $XXX per Blood Product Transfusions]	[None / $XXX per Blood Product Transfusions]
[Blood Product Transfusions] [Coinsurance] [Tier [1]]	[0% - 100% [until the [Blood Product Transfusions] [Tier [1]] Out-of-Pocket Limits are satisfied; [then Tier [2];] [100% thereafter.]]	[0% - 100% [until the [Blood Product Transfusions] [Tier [1]] Out-of-Pocket Limits are satisfied; [then Tier [2];] [100% thereafter.]]	[0% - 100% [until the [Blood Product Transfusions] [Tier [1]] Out-of-Pocket Limits are satisfied; [then Tier [2];] [100% thereafter.]]
[Tier [1]] [Blood Product Transfusions] [Out-of-Pocket Limit] [each [Calendar Year] [Benefit Period] [Time Period] [Plan Year]] [Individual] [Family]	[$0 - $25,000 / Not applicable] [$0 - $75,000 / Not applicable]	[$0 - $25,000 / Not applicable] [$0 - $75,000 / Not applicable]	[$0 - $25,000 / an additional $0 - $10,000] [$0 - $75,000 / an additional $0 - $30,000]
[Blood Product Transfusions] [Coinsurance] [Tier [2]]	[0% - 100% [until the [Blood Product Transfusions] [Tier [2]] Out-of-Pocket Limits are satisfied; [then Tier [X];] [100% thereafter.]]	[0% - 100% [until the [Blood Product Transfusions] [Tier [2]] Out-of-Pocket Limits are satisfied; [then Tier [X];] [100% thereafter.]]	[0% - 100% [until the [Blood Product Transfusions] [Tier [2]] Out-of-Pocket Limits are satisfied; [then Tier [X];] [100% thereafter.]]
[Tier [2]] [Blood Product Transfusions] [Out-of-Pocket Limit] [each [Calendar Year] [Benefit Period] [Time Period] [Plan Year]] [Individual] [Family]	[$0 - $25,000 / Not applicable] [$0 - $75,000 / Not applicable]	[$0 - $25,000 / Not applicable] [$0 - $75,000 / Not applicable]	[$0 - $25,000 / an additional $0 - $10,000] [$0 - $75,000 / an additional $0 - $30,000]
[Blood Product Transfusions] [Coinsurance] [Tier [X]]	[0% - 100% [until the [Blood Product Transfusions] [Tier [X]] Out-of-Pocket Limits are satisfied;] [then Tier	[0% - 100% [until the [Blood Product Transfusions] [Tier [X]] Out-of-Pocket Limits are satisfied	[0% - 100% [until the [Blood Product Transfusions] [Tier [X]] Out-of-Pocket Limits are satisfied;] [then Tier [X +

	[X + [1]];] [100% thereafter.]]	[100% thereafter.]]	[1]];] [100% thereafter.]]
[Tier [X]] [Blood Product Transfusions] Out-of-Pocket Limit [each [Calendar Year] [Benefit Period] [Time Period] [Plan Year]] [Individual] [Family]	[$0 - $25,000 / Not applicable] [$0 - $75,000 / Not applicable]	[$0 - $25,000 / Not applicable] [$0 - $75,000 / Not applicable]	[$0 - $25,000 / an additional $0 - $10,000] [$0 - $75,000 / an additional $0 - $30,000]
[[Blood Product Transfusions] Out-of-Pocket Limits] [Individual] [Family]	[$XXX] [$XXX]	[$XXX] [$XXX]	[$XXX] [$XXX]
[Benefits for [Blood Product Transfusions] are payable at [0-100%] [with a [$10-$100] Copayment] when a [Designated Specialty Service Provider] is used. If a [Designated Specialty Service Provider] is not used, [Covered Charges will be [paid at the [Non-][Participating] [or] [applicable] Coinsurance] [reduced by [$1 - $3,000] [1% - 50%]][limited to [$XXX] per [Calendar] [Plan] Year] [per Covered Person] [after the Covered Person has paid any applicable Copayment, Deductible or other fees.] [These limitations will apply to all treatment rendered by a provider that is not designated as a [Designated Specialty Service Provider] regardless of whether the provider is a [Network Provider,] [Participating Provider,] [or] [Select Participating Provider].]			

BEN: 150.001.001.GE

[**Transplants**:]
[Subject to [Plan] [and] [Inpatient] [and] [Outpatient] [Integrated] Deductible and [Plan] [and] [Inpatient] [and] [Outpatient] Coinsurance [unless otherwise specified]]
[Benefit for Transplants are limited to [Outpatient] [and] [Calendar Year] [and] [Plan Year] [and] [Monthly] [and] [Daily] [Benefit Period] [Per Cause] [and] [Lifetime] Maximum Benefit]
[Donor Expenses are limited to a Maximum Benefit of [$5,000 - $25,000~~$10,000~~]]
[Not Covered]
[The following Covered Transplants are subject to the [Outpatient] [and] [Calendar Year] [and] [Plan Year and] [Monthly] [and] [Daily] [Benefit Period] [Per Cause] [and] [Lifetime] Maximum Benefit]: • [Kidney] • [Cornea] • [Skin]]
[The following Covered Transplants subject to the [Maximum Transplant Benefit] [Outpatient] and [Calendar Year] and [Plan Year] [and] [Monthly] [and] [Daily] [Benefit Period] [Per Cause] [and] [Lifetime] [Maximum Benefit]: • Lung(s) • Heart • Simultaneous heart/lung • Liver • Simultaneous kidney/pancreas • Allogeneic and autologous bone marrow transplant/stem cell rescue]

	[Designated Specialty Service Provider	**[Participating Provider [Benefits] /**	**[Non-[Select] Participating Provider**

	/[Select] Participating Provider /Designated Transplant Provider [Benefits]]	Network Provider [Benefits]] [and Non-Participating/Non-Network Provider]	[Benefits]/ Non-Participating Provider [Benefits]/ Non-Network Provider [Benefits]]
[Maximum Transplant Benefit]	[Lifetime Maximum Benefit] [[$100,000] Benefit Period Maximum] [per Covered Person]	[$100,000] [Lifetime] [Calendar Year] [Plan Year] [Benefit Period] Maximum [Benefit] [per Covered Person]	[$100,000] [Lifetime] [Calendar Year] [Plan Year] [Benefit Period] Maximum [Benefit] [per Covered Person]
[Travel Expenses] will be covered up to a [$5,000 - $20,000~~$10,000~~] Maximum Benefit when a [Designated Specialty Service Provider][Select Participating Provider][Designated Transplant Provider Benefits] is used as described in the Covered Medical Benefits section]			

BEN: 155.001.001.GE

[**Behavioral Health** [**and Substance Abuse**]:]			
[Subject to [Plan] [and] [Inpatient] [and] [Outpatient] [Integrated] [Per Cause] Deductible] [and] [Plan] [and] [Inpatient] [and] [Outpatient] [Coinsurance] [unless otherwise specified].]			
[Benefits for Inpatient treatment in a state licensed [Acute Behavioral Health Inpatient Facility] [or] [Behavioral Health Rehabilitation and Residential Facility] are limited to [$1,000 - $5,000~~$2,500~~] [or] [10-50~~30~~] [days] [whichever is [less] [greater]] each [Calendar Year] [Plan Year] [Benefit Period] [Per Cause] [per] [Covered Person] [Family]]			
[Benefits for Outpatient treatment by a Health Care Practitioner [or a state licensed [Intensive Outpatient Behavioral Health Program] [or] [Partial Hospital and Day Treatment Behavioral Health Facility or Program] are limited to [$50] for each visit up to [[XX] visits] [$250 - $1,000~~$500~~] each [Calendar Year] [Plan Year] [Benefit Period] [Per Cause] [per] [Covered Person] [Family]]			
[Benefits for Inpatient treatment in a state licensed [Acute Behavioral Health Inpatient Facility] [or] [Behavioral Health Rehabilitation and Residential Facility] and Outpatient treatment by a Health Care Practitioner [or a state licensed [Intensive Outpatient Behavioral Health Program] [or] [Partial Hospital and Day Treatment Behavioral Health Facility or Program] are limited to a combined Maximum Benefit of [$2,000 - $6,000~~$3,000~~] each [Calendar Year] [Plan Year] [Benefit Period] [Per Cause] [per] [Covered Person] [Family]]			
[Benefits for Inpatient treatment in a state licensed [Acute Behavioral Health Inpatient Facility] [or] [Behavioral Health Rehabilitation and Residential Facility] and Outpatient treatment by a Health Care Practitioner [or a state licensed [Intensive Outpatient Behavioral Health Program] [or] [Partial Hospital and Day Treatment Behavioral Health Facility or Program] are limited to a Lifetime Maximum Benefit of [$5,000 - $25,000~~$10,000~~] [per] [Covered Person] [Family]]			
[Behavioral Health [and Substance Abuse] Benefit Waiting Period is [[12] months] [[365] days]]			
[The [Behavioral Health] [and Substance Abuse] [Deductible] [and] [Coinsurance] does [not] apply to the [Plan Deductible] [or] [Total Out-of-Pocket Limits.]]			
[The [Behavioral Health] [and Substance Abuse] Coinsurance] will [not] increase to 100% after the Plan Out of Pocket is satisfied.] [The Behavioral Health Coinsurance, not paid by us, will not apply toward any Out of Pocket Limit.]]			
[Not Covered]			
	[[Select] Participating Provider [Benefits]]	**[Participating Provider [Benefits] / Network Provider [Benefits]]**	**[Non-[Select] Participating Provider [Benefits]/ Non-Participating Provider [Benefits]/ Non-Network Provider [Benefits]]**
[[Behavioral Health [and Substance Abuse]] Maximum [Lifetime] [Calendar Year] [Plan Year] [Benefit Period] [Per Cause] [Monthly] [Daily] Benefit]	[$XXX] [[XX] number of visits] [per Covered Person]	[$XXX] [[XX] number of visits] [per Covered Person]	[$XXX] [[XX] number of visits] [per Covered Person]
[[Behavioral Health [and Substance Abuse]] Maximum [Lifetime]	[$XXX] [[XX] number	[$XXX] [[XX] number	[$XXX] [[XX] number of

[Calendar Year] [Plan Year] [Benefit Period] [Per Cause] [Monthly] [Daily] Benefit] [due to an [Accidental Injury] [Injury] [or] [underlying Sickness]	of visits] [per Covered Person]	of visits] [per Covered Person]	visits] [per Covered Person]
[Behavioral Health [and Substance Abuse] Deductible] [Individual] [Integrated] [Family]	[$XXX] [$XXX]	[$XXX] [$XXX]	[$XXX] [$XXX]
[[Non-Participating] [Non-network] Provider Deductible is in addition to the [Participating] [Network] Provider Deductible.]			
[Once [[2] or more Covered Persons have collectively met] the maximum Family Deductible [[has been met]], no additional Deductible will be taken during the [Calendar Year] [Plan Year] [Benefit Period] [Time Period].]			
[Behavioral Health [and Substance Abuse]] [Coinsurance] [Tier [1]]	[0% - 100% [until the [Behavioral Health [and Substance Abuse] [Maximum Benefit is Met] [Tier [1]] Out-of-Pocket Limits are satisfied; [then Tier [2];] [100% thereafter.]]	[0% - 100% [until the [Behavioral Health [and Substance Abuse] [Maximum Benefit is Met] [Tier [1]] Out-of-Pocket Limits are satisfied; [then Tier [2];] [100% thereafter.]]	[0% - 100% [until the [Behavioral Health [and Substance Abuse] [Maximum Benefit is Met] [Tier [1]] Out-of-Pocket Limits are satisfied; [then Tier [2];] [100% thereafter.]]
[Tier [1]] [Behavioral Health [and Substance Abuse]] [Out-of-Pocket Limit] [each [Calendar Year] [Benefit Period] [Time Period] [Plan Year] [Individual] [Family]	[$0 - $25,000 / Not applicable] [$0 - $75,000 / Not applicable]	[$0 - $25,000 / Not applicable] [$0 - $75,000 / Not applicable]	[$0 - $25,000 / an additional $0 - $10,000] [$0 - $75,000 / an additional $0 - $30,000]
[Behavioral Health [and Substance Abuse]][Coinsurance] [Tier [2]]	[0% - 100% [until the [Behavioral Health [and Substance Abuse] [Maximum Benefit is Met] [Tier [2]] Out-of-Pocket Limits are satisfied; [then Tier [X];] [100% thereafter.]]	[0% - 100% [until the [Behavioral Health [and Substance Abuse] [Maximum Benefit is Met] [Tier [2]] Out-of-Pocket Limits are satisfied; [then Tier [X];] [100% thereafter.]]	[0% - 100% [until the [Behavioral Health [and Substance Abuse] [Maximum Benefit is Met] [Tier [2]] Out-of-Pocket Limits are satisfied; [then Tier [X];] [100% thereafter.]]
[Tier [2] [Behavioral Health [and Substance Abuse]] [Out-of-Pocket Limit] [each [Calendar Year] [Benefit Period] [Time Period] [Plan Year] [Individual] [Family]	[$0 - $25,000 / Not applicable] [$0 - $75,000 / Not applicable]	[$0 - $25,000 / Not applicable] [$0 - $75,000 / Not applicable]	[$0 - $25,000 / an additional $0 - $10,000] [$0 - $75,000 / an additional $0 - $30,000]

[Behavioral Health [and Substance Abuse]] [Coinsurance] [Tier [X]]	[0% - 100% [until the [Behavioral Health [and Substance Abuse] [Maximum Benefit is Met] [Tier [X]] Out-of-Pocket Limits are satisfied;] [then Tier [X + [1]];] [100% thereafter.]]	[0% - 100% [until the [Behavioral Health [and Substance Abuse] [Maximum Benefit is Met] [Tier [X]] Out-of-Pocket Limits are satisfied;] [then Tier [X + [1]];] [100% thereafter.]]	[0% - 100% [until the [Behavioral Health [and Substance Abuse] [Maximum Benefit is Met] [Tier [X]] Out-of-Pocket Limits are satisfied;] [then Tier [X + [1]];] [100% thereafter.]]
[Tier [X]] [Behavioral Health [and Substance Abuse]][Out-of-Pocket Limit] [each [Calendar Year] [Benefit Period] [Time Period] [Plan Year] [Individual] [Family]	[$0 - $25,000 / Not applicable] [$0 - $75,000 / Not applicable]	[$0 - $25,000 / Not applicable] [$0 - $75,000 / Not applicable]	[$0 - $25,000 / an additional $0 - $10,000] [$0 - $75,000 / an additional $0 - $30,000]
[[Behavioral Health [and Substance Abuse Services]] [Out-of-Pocket Limits] [Individual] [Family]	[$XXX] [$XXX]	[$XXX] [$XXX]	[$XXX] [$XXX]
[Benefits for Behavioral Health [and Substance Abuse Services] are payable at [0-100%] [with a [$10-$100] Copayment] when a Designated Specialty Service Provider is used. If a Designated Specialty Service Provider is not used, [Covered Charges will be [paid at the [Non-][Participating] [or] [applicable] Coinsurance] [reduced by [$1 - $3,000] [1% - 50%]][limited to [$XXX] per [Calendar] [Plan] Year] [per Covered Person] [after the Covered Person has paid any applicable Copayment, Deductible or other fees.] [These limitations will apply to all treatment rendered by a provider that is not designated as a Designated Specialty Service Provider regardless of whether the provider is a [Network Provider,] [Participating Provider,] [or] [Select Participating Provider].]			

BEN: 160.001.001.GE

[**Substance Abuse**:]
[Subject to [Plan] [and] [Inpatient] [and] [Outpatient] [Integrated] [Per Cause] Deductible] and [Plan] [and] [Inpatient] [and] [Outpatient] Coinsurance [unless otherwise specified]]
[Benefits for Inpatient treatment in a state licensed [Acute Behavioral Health Inpatient Facility] [or] [Behavioral Health Rehabilitation and Residential Facility] are limited to [$1,000 - $5,000~~$2,500~~] [or] [10-50~~30~~] [days] [whichever is [less] [greater]] each [Calendar Year] [Plan Year] [Benefit Period] [Per Cause] [per] [Covered Person] [Family]]
[Benefits for Outpatient treatment by a Health Care Practitioner [or a state licensed [Intensive Outpatient Behavioral Health Program] [or] [Partial Hospital and Day Treatment Behavioral Health Facility or Program] are limited to [$25 - $100~~$50~~] for each visit up to [[XX] visits] [$250 - $100~~$500~~] each [Calendar Year] [Plan Year] [Benefit Period] [Per Cause] [per] [Covered Person] [Family]]
[Benefits for Inpatient treatment in a state licensed [Acute Behavioral Health Inpatient Facility] [or] [Behavioral Health Rehabilitation and Residential Facility] and Outpatient treatment by a Health Care Practitioner [or a state licensed [Intensive Outpatient Behavioral Health Program] [or] [Partial Hospital and Day Treatment Behavioral Health Facility or Program] are limited to a combined Maximum Benefit of [$1,500 - $6,000~~$3,000~~] each [Calendar Year] [Plan Year] [Benefit Period] [Per Cause] [per] [Covered Person] [Family]]
[Benefits for Inpatient treatment in a state licensed [Acute Behavioral Health Inpatient Facility] [or] [Behavioral Health Rehabilitation and Residential Facility] and Outpatient treatment by a Health Care Practitioner [or a state licensed [Intensive Outpatient Behavioral Health Program] [or] [Partial Hospital and Day Treatment Behavioral

Health Facility or Program] are limited to a Lifetime Maximum Benefit of [$5,000 - $20,000~~$10,000~~] [per] [Covered Person] [Family]]			
[Substance Abuse] Benefit Waiting Period is [[12] months] [[365] days]]			
[Not Covered]			
	[[Select] Participating Provider [Benefits]]	**[Participating Provider [Benefits] / Network Provider [Benefits]]**	**[Non-[Select] Participating Provider [Benefits]/ Non-Participating Provider [Benefits]/ Non-Network Provider [Benefits]]**
[[Substance Abuse] Maximum [Lifetime] [Calendar Year] [Plan Year] [Benefit Period] [Per Cause] [Monthly] [Daily] Benefit]	[$XXX] [[XX] number of visits] [per Covered Person]	[$XXX] [[XX] number of visits] [per Covered Person]	[$XXX] [[XX] number of visits] [per Covered Person]
[[Substance Abuse] Maximum [Lifetime] [Calendar Year] [Plan Year] [Benefit Period] [Per Cause] [Monthly] [Daily] Benefit] [due to an [Accidental Injury] [Injury] [or] [underlying Sickness]]	[$XXX] [[XX] number of visits] [per Covered Person]	[$XXX] [[XX] number of visits] [per Covered Person]	[$XXX] [[XX] number of visits] [per Covered Person]
[Substance Abuse Deductible] [Individual] [Integrated] [Family]	[$XXX] [$XXX]	[$XXX] [$XXX]	[$XXX] [$XXX]
[The [Substance Abuse Deductible] does [not] apply to the Plan Deductible or Total Out-of-Pocket Limits.]			
[[Non-Participating] [Non-network] Provider Deductible is in addition to the [Participating] [Network] Provider Deductible.]			
[Once [[2] or more Covered Persons have collectively met] the maximum Family Deductible [has been met], no additional Deductible will be taken during the [Calendar Year] [Plan Year] [Benefit Period] [Time Period].]			
[Substance Abuse] Coinsurance [Tier [1]]	[0% - 100% [until the [Substance Abuse Services] [Tier [1]] Out-of-Pocket Limits are satisfied; [then Tier [2];] [100% thereafter.]]	[0% - 100% [until the [Substance Abuse Services] [Tier [1]] Out-of-Pocket Limits are satisfied; [then Tier [2];] [100% thereafter.]]	[0% - 100% [until the [Substance Abuse Services] [Tier [1]] Out-of-Pocket Limits are satisfied; [then Tier [2];] [100% thereafter.]]
[Tier [1]] [Substance Abuse] Out-of-Pocket Limit [each [Calendar Year] [Benefit Period] [Time Period] [Plan Year]] [Individual] [Family]	[$0 - $25,000 / Not applicable] [$0 - $75,000 / Not applicable]	[$0 - $25,000 / Not applicable] [$0 - $75,000 / Not applicable]	[$0 - $25,000 / an additional $0 - $10,000] [$0 - $75,000 / an additional $0 - $30,000]
[Substance Abuse] [Coinsurance] [Tier [2]]	[0% - 100% [until the [Substance Abuse Services] [Tier [2]] Out-of-Pocket Limits are satisfied; [then Tier [X];] [100% thereafter.]]	[0% - 100% [until the [Substance Abuse Services] [Tier [2]] Out-of-Pocket Limits are satisfied; [then Tier [X];] [100% thereafter.]]	[0% - 100% [until the [Substance Abuse Services] [Tier [2]] Out-of-Pocket Limits are satisfied; [then Tier [X];] [100% thereafter.]]

[Tier [2]] [Substance Abuse] Out-of-Pocket Limit [each [Calendar Year] [Benefit Period] [Time Period] [Plan Year]] [Individual]	[$0 - $25,000 / Not applicable]	[$0 - $25,000 / Not applicable]	[$0 - $25,000 / an additional $0 - $10,000]
[Family]	[$0 - $75,000 / Not applicable]	[$0 - $75,000 / Not applicable]	[$0 - $75,000 / an additional $0 - $30,000]
[Substance Abuse] [Coinsurance] [Tier [X]]	[0% - 100% [until the [Substance Abuse Services] [Tier [X]] Out-of-Pocket Limits are satisfied;] [then Tier [X + [1]];] [100% thereafter.]]	[0% - 100% [until the [Substance Abuse Services] [Tier [X]] Out-of-Pocket Limits are satisfied;] [then Tier [X + [1]];] [100% thereafter.]]	[0% - 100% [until the [Substance Abuse Services] [Tier [X]] Out-of-Pocket Limits are satisfied;] [then Tier [X + [1]];] [100% thereafter.]]
[Tier [X]] [Substance Abuse] Out-of-Pocket Limit [each [Calendar Year] [Benefit Period] [Time Period] [Plan Year]] [Individual]	[$0 - $25,000 / Not applicable]	[$0 - $25,000 / Not applicable]	[$0 - $25,000 / an additional $0 - $10,000]
[Family]	[$0 - $75,000 / Not applicable]	[$0 - $75,000 / Not applicable]	[$0 - $75,000 / an additional $0 - $30,000]
[Substance Abuse Services] Out-of-Pocket Limits] [Individual]	[$XXX]	[$XXX]	[$XXX]
[Family]	[$XXX]	[$XXX]	[$XXX]
[Benefits for [Substance Abuse Services] are payable at [0-100%] [with a [$10-$100] Copayment] when a [Designated Specialty Service Provider] is used. If a [Designated Specialty Service Provider] is not used, [Covered Charges will be [paid at the [Non-][Participating] [or] [applicable] Coinsurance] [reduced by [$1 - $3,000] [1% - 50%]][limited to [$XXX] per [Calendar] [Plan] Year] [per Covered Person] [after the Covered Person has paid any applicable Copayment, Deductible or other fees.] [These limitations will apply to all treatment rendered by a provider that is not designated as a [Designated Specialty Service Provider] regardless of whether the provider is a [Network Provider,] [Participating Provider,] [or] [Select Participating Provider].]			

BEN: 165.001.001.GE

[**Reconstructive Surgery**:]			
[All services, supplies and treatments apply to the [Inpatient] [and] [Outpatient] [and] [Calendar Year] [Plan Year] [Benefit Period] [Per Cause] Maximum Benefit]			
[Subject to [Plan] [Integrated] [Inpatient] [Outpatient] [Per Cause] Deductible] and [Plan] [Inpatient] [Outpatient] Coinsurance [unless otherwise specified]]			
	[[Select] Participating Provider [Benefits]]	**[Participating Provider [Benefits] / Network Provider [Benefits]]**	**[Non-[Select] Participating Provider [Benefits]/ Non-Participating Provider [Benefits]/ Non-Network Provider [Benefits]]**

[[Reconstructive Surgery] [Lifetime] [Calendar Year] [Plan Year] [Benefit Period] [Per Cause] [Monthly] [Daily] Maximum Benefit]	[$XXX] [per Covered Person]	[$XXX] [per Covered Person]	[$XXX] [per Covered Person]
[[Reconstructive Surgery] [Lifetime] [Calendar Year] [Plan Year] [Benefit Period] [Per Cause] [Monthly] [Daily] Maximum Benefit] [due to an [Accidental Injury] [Injury] [or] [underlying Sickness]	[$XXX] [per Covered Person]	[$XXX] [per Covered Person]	[$XXX] [per Covered Person]

BEN: 170.001.001.GE

[**Dental Services**:]			
[All services, supplies and treatments apply to the [Outpatient] [and] [Calendar Year] [and] [Plan Year] [and] [Benefit Period] [Per Cause] Maximum Benefit]			
[Subject to [Plan] [and] [Outpatient] [Integrated] [Per Cause] Deductible] and [Plan] [and] [Outpatient] Coinsurance [unless otherwise specified]]			
[Benefits for Dental Services are limited to a Maximum [Lifetime] [Calendar Year] [Plan Year] [Benefit Period] [Per Cause] [Monthly] [Daily] Benefit of [$1,000 - $5,000~~$2,000~~] [unless due to an Accidental Injury [Injury] [or underlying Sickness] [per Covered Person]]			
[Benefits are limited to conditions present at birth or diagnosed before age [5]]			
[Treatment must begin within [90 days] and be completed within [365 days] of the Dental Injury.]			
[Dental Services Benefit Waiting Period is [12][Months] [[365] days].]			
[Not Covered]			
	[[Select] Participating Provider [Benefits]]	**[Participating Provider [Benefits] / Network Provider [Benefits]]**	**[Non-[Select] Participating Provider [Benefits]/ Non-participating Provider [Benefits]/ Non-Network Provider [Benefits]]**
[[Dental Services] Maximum [Lifetime] [Calendar Year] [Plan Year] [Benefit Period] [Per Cause] [Monthly] [Daily] Benefit]	[$XXX] [per Covered Person]	[$XXX] [per Covered Person]	[$XXX] [per Covered Person]
[Benefits for Dental Services are payable at [0-100%] [with a [$10-$100] Copayment] when a [Designated Specialty Service Provider] is used. If a [Designated Specialty Service Provider] is not used, [Covered Charges will be [paid at the [Non-][Participating] [or] [applicable] Coinsurance] [reduced by [$1 - $3,000] [1% - 50%]][limited to [$XXX] per [Calendar] [Plan] Year] [per Covered Person] [after the Covered Person has paid any applicable Copayment, Deductible or other fees.] [These limitations will apply to all treatment rendered by a provider that is not designated as a [Designated Specialty Service Provider] regardless of whether the provider is a [Network Provider,] [Participating Provider,] [or] [Select Participating Provider].]			

BEN: 175.001.001.GE

[**Intravenous Injectable Parenteral Drug Therapy** [**and Specialty Pharmaceuticals**]:]			
[All services, supplies and treatments apply to the [Outpatient] [Calendar Year] [Plan Year] [Benefit Period] [Per Cause] Maximum Benefit]			
[Subject to [Plan] [Outpatient] [Integrated] [Per Cause] Deductible] and Coinsurance [unless otherwise specified]]			
[Benefits for [Intravenous Injectable Parenteral Drug Therapy] [and Specialty Pharmaceuticals] Services are limited to a Maximum [Lifetime] [Calendar Year] [Plan Year] [Benefit Period] [Per Cause] [Monthly] [Daily] Benefit of [$XXX] [per Covered Person]]			
[Not Covered]			
	[[Select] Participating	**[Participating**	**[Non-[Select]**

	Provider [Benefits]]	**Provider [Benefits] / Network Provider [Benefits]]**	**Participating Provider [Benefits]/ Non-Participating Provider [Benefits]/ Non-Network Provider [Benefits]]**
[[Intravenous Injectable Parenteral Drug Therapy] [and Specialty Pharmaceuticals] Services] Maximum [Lifetime] [Calendar Year] [Plan Year] [Benefit Period] [Per Cause] [Monthly] [Daily] Benefit]	[$XXX] [per Covered Person]	[$XXX] [per Covered Person]	[$XXX] [per Covered Person]
[Benefits for [Intravenous Injectable Parenteral Drug Therapy Service] are payable at [0-100%] [with a [$10-$100] Copayment] when a Designated Specialty Service Provider is used. If a Designated Specialty Service Provider is not used, [Covered Charges will be [paid at the [Non-][Participating] [or] [applicable] Coinsurance] [reduced by [$1 - $3,000] [1% - 50%]][limited to [$XXX] per [Calendar] [Plan] Year] [per Covered Person] [after the Covered Person has paid any applicable Copayment, Deductible or other fees.] [These limitations will apply to all treatment rendered by a provider that is not designated as a Designated Specialty Service Provider regardless of whether the provider is a [Network Provider,] [Participating Provider,] [or] [Select Participating Provider].]			

BEN: 180.001.001.GE

[**Non-Intravenous Injectable Parenteral Drug Therapy**:]			
[All services, supplies and treatments apply to the [Outpatient] [Calendar Year] [Plan Year] [Benefit Period] [Per Cause] Maximum Benefit]			
[Subject to [Plan] [and] [Outpatient] [and] [Inpatient] [Integrated] [Per Cause] Deductible] and [Plan] [and] [Outpatient] and [Inpatient] Coinsurance [unless otherwise specified]			
[Benefits for Non-Intravenous Injectable Drug Therapy Services are limited to a Maximum [Lifetime] [Calendar Year] [Plan Year] [Benefit Period] [Per Cause] [Monthly] [Daily] Benefit of [$XXX] [per Covered Person]]			
[Not Covered]			
	[[Select] Participating Provider [Benefits]]	**[Participating Provider [Benefits] / Network Provider [Benefits]]**	**[Non-[Select] Participating Provider [Benefits]/ Non-Participating Provider [Benefits]/ Non-Network Provider [Benefits]]**
[[Non-Intravenous Injectable Drug Therapy Services] Maximum [Lifetime] [Calendar Year] [Plan Year] [Benefit Period] [Per Cause] [Monthly] [Daily] Benefit]	[$XXX] [per Covered Person]	[$XXX] [per Covered Person]	[$XXX] [per Covered Person]
[Benefits for [Non-Intravenous Injectable Drug Therapy Services] are payable at [0-100%] [with a [$10-$100] Copayment] when a [Designated Specialty Service Provider] is used. If a [Designated Specialty Service Provider] is not used, [Covered Charges will be [paid at the [Non-][Participating] [or] [applicable] Coinsurance] [reduced by [$1 - $3,000] [1% - 50%]][limited to [$XXX] per [Calendar] [Plan] Year] [per Covered Person] [after the Covered Person has paid any applicable Copayment, Deductible or other fees.] [These limitations will apply to all treatment rendered by a provider that is not designated as a [Designated Specialty Service Provider] regardless of whether the provider is a [Network Provider,] [Participating Provider,] [or] [Select Participating Provider].]			

BEN: 185.001.001.GE

[[**Telemedicine Services**] [**and**] [**Telehealth Services**]:]
[All services, supplies and treatments apply to the [Outpatient] [Calendar Year] [Plan Year] [Benefit Period] [Per Cause] Maximum Benefit]
[Subject to [Plan] [Outpatient] [Integrated] [Per Cause] Deductible] and Coinsurance [unless otherwise specified].]

[Benefits for [[Telemedicine Services] [and] [Telehealth Services]]are limited to a Maximum [Lifetime] [Calendar Year] [Plan Year] [Monthly] [Daily] [Benefit Period] [Per Cause] Benefit of [$1,000 - $5,000~~$2,000~~] [per Covered Person]]			
[Benefits for [[Telemedicine Services] [and] [Telehealth Services]] are limited to a Maximum Benefit of [[$XX] for each visit] [0-12 visits] [or] [up to [$XXX] each [Calendar] [Plan] [Benefit] Year] [per Covered Person].]			
[[Telemedicine Services] [and] [Telehealth Services]] Benefit Waiting Period is [[6] months] [[180] days]]]			
[Not Covered]			
[[Plan] [Integrated] [Per Cause] Deductible] [and Coinsurance] will be waived for the first [$50 - $500] [0-12 visits] of Covered Services performed [by a [Participating Provider] [Network Provider] [Retail Health Clinic]] [per] [Covered Person] [covered child] [Family] [per [Calendar Year] [Plan Year] [Benefit Period] [Per Cause] [after a [12 month] [365 day] Benefit Waiting Period][subject to a [$5 - $75] copayment].]			
	[[Select] Participating Provider [Benefits]]	**[Participating Provider [Benefits] / Network Provider [Benefits]]**	**[Non-[Select] Participating Provider [Benefits]/ Non-Participating Provider [Benefits]/ Non-Network Provider [Benefits]]**
[[Telemedicine Services] [and] [Telehealth Services]] Maximum [Lifetime] [Calendar Year] [Plan Year] [Benefit Period] [Per Cause] [Monthly] [Daily] Benefit]	[$XXX] [per Covered Person]	[$XXX] [per Covered Person]	[$XXX] [per Covered Person]
[[Telemedicine Services] [and] [Telehealth Services]]Deductible] [Individual] [Integrated] [Family]	[$XXX] [$XXX]	[$XXX] [$XXX]	[$XXX] [$XXX]
The [[Telemedicine Services] [and] [Telehealth Services]] Deductible] does [not] apply to the Plan Deductible or Total Out-of-Pocket Limits.			
[[Non-Participating] [Non-network] Provider Deductible is in addition to the [Participating] [Network] Provider Deductible.]			
[Once [[2] or more Covered Persons have collectively met] the maximum Family Deductible [has been met], no additional Deductible will be taken during the [Calendar Year] [Plan Year] [Benefit Period] [Time Period].]			
[Access] [Fee]	[None / $XXX per [[Telemedicine Services] [and] [Telehealth Services]]	[None / $XXX per [[Telemedicine Services] [and] [Telehealth Services]]	[None / $XXX per [[Telemedicine Services] [and] [Telehealth Services]]
[Copayment]	[None / $XXX per [[Telemedicine Services] [and] [Telehealth Services]]	[None / $XXX per [[Telemedicine Services] [and] [Telehealth Services]]	[None / $XXX per [[Telemedicine Services] [and] [Telehealth Services]]
[[Telemedicine Services] [and] [Telehealth Services]][Coinsurance] [Tier [1]]	[0% - 100% [until the [[Telemedicine Services] [and] [Telehealth Services]] [Tier [1]] Out-of-Pocket Limits are satisfied; [then Tier [2];] [100% thereafter.]]	[0% - 100% [until the [[Telemedicine Services] [and] [Telehealth Services] [Tier [1]] Out-of-Pocket Limits are satisfied; [then Tier [2];] [100% thereafter.]]	[0% - 100% [until the [[Telemedicine Services] [and] [Telehealth Services] [Tier [1]] Out-of-Pocket Limits are satisfied; [then Tier [2];] [100% thereafter.]]

[Tier [1]] [[Telemedicine Services] [and] [Telehealth Services]][Out-of-Pocket Limit][each [Calendar Year] [Benefit Period] [Time Period] [Plan Year]] [Individual] [Family]	[$0 - $25,000 / Not applicable] [$0 - $75,000 / Not applicable]	[$0 - $25,000 / Not applicable] [$0 - $75,000 / Not applicable]	[$0 - $25,000 / an additional $0 - $10,000] [$0 - $75,000 / an additional $0 - $30,000]
[[Telemedicine Services] [and] [Telehealth Services]] [Coinsurance] [Tier [2]]	[0% - 100% [until the [[Telemedicine Services] [and] [Telehealth Services] [Tier [2]] Out-of-Pocket Limits are satisfied; [then Tier [X];] [100% thereafter.]]	[0% - 100% [until the [[Telemedicine Services] [and] [Telehealth Services] [Tier [2]] Out-of-Pocket Limits are satisfied; [then Tier [X];] [100% thereafter.]]	[0% - 100% [until the [[Telemedicine Services] [and] [Telehealth Services]] [Tier [2]] Out-of-Pocket Limits are satisfied; [then Tier [X];] [100% thereafter.]]
[Tier [2]] [[Telemedicine Services] [and] [Telehealth Services]][Out-of-Pocket Limit] [each [Calendar Year] [Benefit Period] [Time Period] [Plan Year]] [Individual] [Family]	[$0 - $25,000 / Not applicable] [$0 - $75,000 / Not applicable]	[$0 - $25,000 / Not applicable] [$0 - $75,000 / Not applicable]	[$0 - $25,000 / an additional $0 - $10,000] [$0 - $75,000 / an additional $0 - $30,000]
[[Telemedicine Services] [and] [Telehealth Services]] [Coinsurance] [Tier [X]]	[0% - 100% [until the [[Telemedicine Services] [and] [Telehealth Services] [Tier [X]] Out-of-Pocket Limits are satisfied;] [then Tier [X + [1]];] [100% thereafter.]]	[0% - 100% [until the [[Telemedicine Services] [and] [Telehealth Services] [Tier [X]] Out-of-Pocket Limits are satisfied;] [then Tier [X + [1]];] [100% thereafter.]]	[0% - 100% [until the [[Telemedicine Services] [and] [Telehealth Services] [Tier [X]] Out-of-Pocket Limits are satisfied;] [then Tier [X + [1]];] [100% thereafter.]]
[Tier [X]] [[Telemedicine Services] [and] [Telehealth Services]][Out-of-Pocket Limit][each [Calendar Year] [Benefit Period] [Time Period] [Plan Year]] [Individual] [Family]	[$0 - $25,000 / Not applicable] [$0 - $75,000 / Not applicable]	[$0 - $25,000 / Not applicable] [$0 - $75,000 / Not applicable]	[$0 - $25,000 / an additional $0 - $10,000] [$0 - $75,000 / an additional $0 - $30,000]
[[Telemedicine Services] [and]			

[Telehealth Services]] Out-of-Pocket Limits] [Individual] [Family]	[$XXX] [$XXX]	[$XXX] [$XXX]	[$XXX] [$XXX]
[Benefits for [Telemedicine Services] [and] [Telehealth Services] are payable at [0-100%] [with a [$10-$100] Copayment] when a [Designated Specialty Service Provider] is used. If a [Designated Specialty Service Provider] is not used, [Covered Charges will be [paid at the [Non-][Participating] [or] [applicable] Coinsurance] [reduced by [$1 - $3,000] [1% - 50%]][limited to [$XXX] per [Calendar] [Plan] Year] [per Covered Person] [after the Covered Person has paid any applicable Copayment, Deductible or other fees.] [These limitations will apply to all treatment rendered by a provider that is not designated as a [Designated Specialty Service Provider] regardless of whether the provider is a [Network Provider,] [Participating Provider,] [or] [Select Participating Provider].]			

BEN: 190.001.001.GE

[[**Out of Network**][**Travel Benefit**]:]			
[All services, supplies and treatments apply to the [Outpatient] [Calendar Year] [Plan Year] [Benefit Period] [Per Cause] Maximum Benefit]			
[Subject to [Plan] [Inpatient][and] [and][Outpatient] [Integrated] [Per Cause] Deductible] and [Plan] [and][Inpatient][and][Outpatient]Coinsurance [unless otherwise specified]]			
[Benefits are limited to [2] [Network][Participating] [Provider] [Office Visits] and [up to] [$250 - $1,000~~$500~~] for [Diagnostic Imaging Services] [and] [Laboratory Services]]			
[Out of Network] [Travel Benefit Waiting Period is [[60] days].]			
[Not Covered]			
	[Primary Care Physician / [Select] Participating Provider [Benefits]]	**[Participating Provider [Benefits] / Network Provider [Benefits]]**	**[Non-[Select] Participating Provider [Benefits]/ Non-Participating Provider [Benefits]/ Non-Network Provider [Benefits]]**
[Out of Network] [Travel Benefit] Maximum [Lifetime] [Calendar Year] [Plan Year] [Benefit Period] [Per Cause] [Monthly] [Daily] Benefit]	[$XXX] [per Covered Person]	[$XXX] [per Covered Person]	[$XXX] [per Covered Person]
[Out of Network] [Travel Benefit Deductible] [Individual] [Integrated] [Family]	[$XXX] [$XXX]	[$XXX] [$XXX]	[$XXX] [$XXX]
[The [Out of Network] Travel Benefit Deductible] does [not] apply to the Plan Deductible or Total Out-of-Pocket Limits.]			
[[Non-Participating] [Non-network] Provider Deductible is in addition to the [Participating] [Network] Provider Deductible.]			
[Once [[2] or more Covered Persons have collectively met] the maximum Family Deductible [has been met], no additional Deductible will be taken during the [Calendar Year] [Plan Year] [Benefit Period] [Time Period].]			
[Access] [Fee]	[None / $XXX per Travel Benefit Service]	[None / $XXX per Travel Benefit Service]	[None / $XXX per Travel Benefit Service]
[Copayment]	[None / $XXX per Travel Benefit Service]	[None / $XXX per Travel Benefit Service]	[None / $XXX per Travel Benefit Service]

[Out of Network] [Travel Benefit] [Coinsurance] [Tier [1]]	[0% - 100% [until the [Out of Network] [Travel Benefit] [Tier [1]] Out-of-Pocket Limits are satisfied; [then Tier [2];] [100% thereafter.]]	[0% - 100% [until the [Out of Network] [Travel Benefit] [Tier [1]] Out-of-Pocket Limits are satisfied; [then Tier [2];] [100% thereafter.]]	[0% - 100% [until the [Out of Network] [Travel Benefit] [Tier [1]] Out-of-Pocket Limits are satisfied; [then Tier [2];] [100% thereafter.]]
[Tier [1]] [Out of Network] [Travel Benefit] Out-of-Pocket Limit [each [Calendar Year] [Benefit Period] [Time Period] [Plan Year]] [Individual]	[$0 - $25,000 / Not applicable]	[$0 - $25,000 / Not applicable]	[$0 - $25,000 / an additional $0 - $10,000]
[Family]	[$0 - $75,000 / Not applicable]	[$0 - $75,000 / Not applicable]	[$0 - $75,000 / an additional $0 - $30,000]
[Out of Network] [Travel Benefit] [Coinsurance] [Tier [2]]	[0% - 100% [until the [Out of Network] [Travel Benefit] [Tier [2]] Out-of-Pocket Limits are satisfied; [then Tier [X];] [100% thereafter.]]	[0% - 100% [until the [Out of Network] [Travel Benefit] [Tier [2]] Out-of-Pocket Limits are satisfied; [then Tier [X];] [100% thereafter.]]	[0% - 100% [until the [Out of Network] [Travel Benefit] [Tier [2]] Out-of-Pocket Limits are satisfied; [then Tier [X];] [100% thereafter.]]
[Tier [2]] [Out of Network] [Travel Benefit] Out-of-Pocket Limit [each [Calendar Year] [Benefit Period] [Time Period] [Plan Year]] [Individual]	[$0 - $25,000 / Not applicable]	[$0 - $25,000 / Not applicable]	[$0 - $25,000 / an additional $0 - $10,000]
[Family]	[$0 - $75,000 / Not applicable]	[$0 - $75,000 / Not applicable]	[$0 - $75,000 / an additional $0 - $30,000]
[Out of Network] [Travel Benefit] [Coinsurance] [Tier [X]]	[0% - 100% [until the [Out of Network] [Travel Benefit] [Tier [X]] Out-of-Pocket Limits are satisfied;] [then Tier [X + [1]];] [100% thereafter.]]	[0% - 100% [until the [Out of Network] [Travel Benefit] [Tier [X]] Out-of-Pocket Limits are satisfied;] [then Tier [X + [1]];] [100% thereafter.]]	[0% - 100% [until the [Out of Network] [Travel Benefit] [Tier [X]] Out-of-Pocket Limits are satisfied;] [then Tier [X + [1]];] [100% thereafter.]]
[Tier [X]] [Out of Network] [Travel Benefit] Out-of-Pocket Limit [each [Calendar Year] [Benefit Period] [Time Period] [Plan Year]] [Individual]	[$0 - $25,000 / Not applicable]	[$0 - $25,000 / Not applicable]	[$0 - $25,000 / an additional $0 - $10,000]
[Family]	[$0 - $75,000 / Not	[$0 - $75,000 / Not	[$0 - $75,000 / an

	applicable]	applicable]	additional $0 - $30,000]
[[Out of Network] [Travel Benefit] Out-of-Pocket Limits] [Individual] [Family]	[$XXX] [$XXX]	[$XXX] [$XXX]	[$XXX] [$XXX]

BEN: 195.001.001.GE

[**Choice of Network Service Area Benefit**:]
[All services, supplies and treatments apply to the [Plan] [and][Outpatient] [and] [Inpatient] [and] [Calendar Year] [Plan Year] [Benefit Period] Maximum Benefit]]
[Subject to [Plan] [and][Outpatient] [and] [Inpatient][and][International Coverage][and] [Integrated] [Per Cause] Deductible] and [Plan] [and][Outpatient] [and] [Inpatient]Coinsurance [unless otherwise specified].]
[Not Covered]

BEN: 200.001.GE

[Nationwide Network Benefit:]
[All services, supplies and treatments apply to the [Plan] [and][Outpatient] [and] [Inpatient] [and] [Calendar Year] [Plan Year] [Benefit Period] Maximum Benefit]]
[Subject to [Plan] [and][Outpatient] [and] [Inpatient][and] [Integrated] [Per Cause] Deductible] and [Plan] [and][Outpatient] [International Coverage] [and] [Inpatient]Coinsurance [unless otherwise specified].]
[Not Covered]

BEN: 205.001.GE

[**International Coverage**:]
[All services, supplies and treatments apply to the [Plan] [and][Outpatient] [and] [Inpatient] [and][International Coverage] [Calendar Year] [Plan Year] [Benefit Period] Maximum Benefit]]
[Subject to [Plan] [and][Outpatient] [and] [Inpatient][and][International Coverage][and] [Integrated] [Per Cause] Deductible] and [Plan] [and][Outpatient] [International Coverage] [and] [Inpatient]Coinsurance [unless otherwise specified].]
[International Coverage Benefits are limited to a Maximum of [$XXX][for services rendered outside the United States of America]].
[International Coverage is subject to the International Coverage Deductible [and Coinsurance] then Covered Charges are paid at [100%] up to [$XX], Covered Charges are then subject the [Plan] [and][Outpatient] [and] [Inpatient] [Per Cause] Deductible] and [Plan] [and][Outpatient] [and] [Inpatient]Coinsurance.]]
[International Coverage Benefit Waiting Period is [90 days].]
[Not Covered]

	[Primary Care Physician / [Select] Participating Provider [Benefits]]	**[Participating Provider [Benefits] / Network Provider [Benefits]]**	**[Non-[Select] Participating Provider [Benefits]/ Non-Participating Provider [Benefits]/ Non-Network Provider [Benefits]]**
[[International Coverage] Maximum[Lifetime] [Calendar Year] [Plan Year] [Monthly] [Daily]	[$XXX] [Per Covered Person]	[$XXX] [Per Covered Person]	[$XXX] [Per Covered Person]

Benefit]			
[[International Coverage] Maximum [Lifetime] [Calendar Year] [Plan Year] [Monthly] [Daily] Benefit] [due to an [Accidental Injury] [Injury] [or] [underlying Sickness]]	[$XXX] [Per Covered Person]	[$XXX] [Per Covered Person]	[$XXX] [Per Covered Person]
[International Coverage Deductible] [Individual] [Integrated] [Family]	[$XXX] [$XXX]	[$XXX] [$XXX]	[$XXX] [$XXX]
[The [International Covered Deductible] does [not] apply to the Plan Deductible or Total Out-of-Pocket Limits.]			
[[Non-Participating] [Non-network] Provider Deductible is in addition to the [Participating] [Network] Provider Deductible.]			
[Once [[2] or more Covered Persons have collectively met] the maximum Family Deductible [has been met], no additional Deductible will be taken during the [Calendar Year] [Plan Year] [Benefit Period] [Time Period].]			
[Access] [Fee]	[None / $XXX per International Coverage Service]	[None / $XXX per International Coverage Service]	[None / $XXX per International Coverage Service]
[Copayment]	[None / $XXX per International Coverage Service]	[None / $XXX per International Coverage Service]	[None / $XXX per International Coverage Service]
[International Coverage] [Coinsurance] [Tier [1]]	[0% - 100% [until the [International Coverage] [Tier [1]] Out-of-Pocket Limits are satisfied; [then Tier [2];] [100% thereafter.]]	[0% - 100% [until the [International Coverage] [Tier [1]] Out-of-Pocket Limits are satisfied; [then Tier [2];] [100% thereafter.]]	[0% - 100% [until the [International Coverage] [Tier [1]] Out-of-Pocket Limits are satisfied; [then Tier [2];] [100% thereafter.]]
[Tier [1]] [International Coverage] [Out-of-Pocket Limit] [each [Calendar Year] [Benefit Period] [Time Period] [Plan Year]] [Individual] [Family]	[$0 - $25,000 / Not applicable] [$0 - $75,000 / Not applicable]	[$0 - $25,000 / Not applicable] [$0 - $75,000 / Not applicable]	[$0 - $25,000 / an additional $0 - $10,000] [$0 - $75,000 / an additional $0 - $30,000]
[International Coverage] [Coinsurance] [Tier [2]]	[0% - 100% [until the [International Coverage] [Tier [2]] Out-of-Pocket Limits are satisfied; [then Tier [X];] [100% thereafter.]]	[0% - 100% [until the [International Coverage] [Tier [2]] Out-of-Pocket Limits are satisfied; [then Tier [X];] [100% thereafter.]]	[0% - 100% [until the [International Coverage] [Tier [2]] Out-of-Pocket Limits are satisfied; [then Tier [X];] [100% thereafter.]]
[Tier [2]] [International Coverage] [Out-of-Pocket Limit] [each [Calendar Year] [Benefit Period] [Time Period] [Plan Year]] [Individual]	[$0 - $25,000 / Not applicable]	[$0 - $25,000 / Not applicable]	[$0 - $25,000 / an additional

[Family]	[$0 - $75,000 / Not applicable]	[$0 - $75,000 / Not applicable]	$0 - $10,000] [$0 - $75,000 / an additional $0 - $30,000]
[International Coverage] [Coinsurance] [Tier [X]]	[0% - 100% [until the [International Coverage] [Tier [X]] Out-of-Pocket Limits are satisfied;] [then Tier [X + [1]];] [100% thereafter.]]	[0% - 100% [until the [International Coverage] [Tier [X]] Out-of-Pocket Limits are satisfied;] [then Tier [X + [1]];] [100% thereafter.]]	[0% - 100% [until the [International Coverage] [Tier [X]] Out-of-Pocket Limits are satisfied;] [then Tier [X + [1]];] [100% thereafter.]]
[Tier [X]] [International Coverage] [Out-of-Pocket Limit] [each [Calendar Year] [Benefit Period] [Time Period] [Plan Year]] [Individual]	[$0 - $25,000 / Not applicable]	[$0 - $25,000 / Not applicable]	[$0 - $25,000 / an additional $0 - $10,000]
[Family]	[$0 - $75,000 / Not applicable]	[$0 - $75,000 / Not applicable]	[$0 - $75,000 / an additional $0 - $30,000]
[[International Coverage] [Out-of-Pocket Limits]] [Individual]	[$XXX]	[$XXX]	[$XXX]
[Family]	[$XXX]	[$XXX]	[$XXX]

BEN: 210.001.001.GE

[**Travel Benefit**:]			
[All services, supplies and treatments apply to the [Outpatient] [Calendar Year] [Plan Year] [Benefit Period] [Per Cause] Maximum Benefit]			
[Subject to [Plan] [Inpatient][and] [and][Outpatient] [Integrated] [Per Cause] Deductible] and [Plan] [and][Inpatient][and][Outpatient]Coinsurance [unless otherwise specified]]			
[Benefits are limited to [2] [Network][Participating] [Provider] [Office Visits] and [up to] [$500] for [Diagnostic Imaging Services] [and] [Laboratory Services]]			
[Travel Benefit Waiting Period is [[60] days].]			
[Not Covered]			
	[Primary Care Physician / [Select] Participating Provider [Benefits]]	**[Participating Provider [Benefits] / Network Provider [Benefits]]**	**[Non-[Select] Participating Provider [Benefits]/ Non-Participating Provider [Benefits]/ Non-Network Provider [Benefits]]**
[Travel Benefit] Maximum [Lifetime] [Calendar Year] [Plan Year] [Benefit Period] [Per Cause] [Monthly] [Daily] Benefit]	[$XXX] [per Covered Person]	[$XXX] [per Covered Person]	[$XXX] [per Covered Person]
[Travel Benefit Deductible]			

[Individual] [Integrated] [Family]	[$XXX] [$XXX]	[$XXX] [$XXX]	[$XXX] [$XXX]
[The Travel Benefit Deductible] does [not] apply to the Plan Deductible or Total Out-of-Pocket Limits.]			
[[Non-Participating] [Non-network] Provider Deductible is in addition to the [Participating] [Network] Provider Deductible.]			
[Once [[2] or more Covered Persons have collectively met] the maximum Family Deductible [has been met], no additional Deductible will be taken during the [Calendar Year] [Plan Year] [Benefit Period] [Time Period].]			
[Access] [Fee]	[None / $XXX per Travel Benefit Service]	[None / $XXX per Travel Benefit Service]	[None / $XXX per Travel Benefit Service]
[Copayment]	[None / $XXX per Travel Benefit Service]	[None / $XXX per Travel Benefit Service]	[None / $XXX per Travel Benefit Service]
[Travel Benefit] [Coinsurance] [Tier [1]]	[0% - 100% [until the [Travel Benefit] [Tier [1]] Out-of-Pocket Limits are satisfied; [then Tier [2];] [100% thereafter.]]	[0% - 100% [until the [Travel Benefit] [Tier [1]] Out-of-Pocket Limits are satisfied; [then Tier [2];] [100% thereafter.]]	[0% - 100% [until the [Travel Benefit] [Tier [1]] Out-of-Pocket Limits are satisfied; [then Tier [2];] [100% thereafter.]]
[Tier [1]] [Travel Benefit] Out-of-Pocket Limit [each [Calendar Year] [Benefit Period] [Time Period] [Plan Year]] [Individual] [Family]	[$0 - $25,000 / Not applicable] [$0 - $75,000 / Not applicable]	[$0 - $25,000 / Not applicable] [$0 - $75,000 / Not applicable]	[$0 - $25,000 / an additional $0 - $10,000] [$0 - $75,000 / an additional $0 - $30,000]
[[Travel Benefit] [Coinsurance] [Tier [2]]	[0% - 100% [until the [Travel Benefit] [Tier [2]] Out-of-Pocket Limits are satisfied; [then Tier [X];] [100% thereafter.]]	[0% - 100% [until the [Travel Benefit] [Tier [2]] Out-of-Pocket Limits are satisfied; [then Tier [X];] [100% thereafter.]]	[0% - 100% [until the [Travel Benefit] [Tier [2]] Out-of-Pocket Limits are satisfied; [then Tier [X];] [100% thereafter.]]
[Tier [2]] [Travel Benefit] Out-of-Pocket Limit [each [Calendar Year] [Benefit Period] [Time Period] [Plan Year]] [Individual] [Family]	[$0 - $25,000 / Not applicable] [$0 - $75,000 / Not applicable]	[$0 - $25,000 / Not applicable] [$0 - $75,000 / Not applicable]	[$0 - $25,000 / an additional $0 - $10,000] [$0 - $75,000 / an additional $0 - $30,000]
[Travel Benefit] [Coinsurance] [Tier [X]]	[0% - 100% [until the [Travel Benefit] [Tier [X]] Out-of-Pocket Limits are satisfied;] [then Tier [X + [1]];] [100% thereafter.]]	[0% - 100% [until the [Travel Benefit] [Tier [X]] Out-of-Pocket Limits are satisfied;] [then Tier [X + [1]];] [100% thereafter.]]	[0% - 100% [until the [Travel Benefit] [Tier [X]] Out-of-Pocket Limits are satisfied;] [then Tier [X + [1]];] [100% thereafter.]]

[Tier [X]] [Travel Benefit] Out-of-Pocket Limit [each [Calendar Year] [Benefit Period] [Time Period] [Plan Year]] [Individual]	[$0 - $25,000 / Not applicable]	[$0 - $25,000 / Not applicable]	[$0 - $25,000 / an additional $0 - $10,000]
[Family]	[$0 - $75,000 / Not applicable]	[$0 - $75,000 / Not applicable]	[$0 - $75,000 / an additional $0 - $30,000]
[Travel Benefit] Out-of-Pocket Limits] [Individual]	[$XXX]	[$XXX]	[$XXX]
[Family]	[$XXX]	[$XXX]	[$XXX]

[Repatriation Services:]			
[All services, supplies and treatments apply to the [Outpatient] [and] [Calendar Year] [and] [Plan Year] [Benefit Period] [Per Cause] Maximum Benefit]			
[Subject to [Plan] [and] [Outpatient] [Integrated] [Per Cause] Deductible] and [Plan] [and] [Outpatient] Coinsurance [unless otherwise specified]]			
[Benefits for Repatriation Services are limited to a Maximum [Lifetime] [Calendar Year] [Plan Year] [Benefit Period] [Per Cause] [Monthly] [Daily] Benefit of [$XXX]]			
[Benefits for Repatriation Services are limited to a Maximum Benefit of [[$10,000] [per Covered Person].]			
[Repatriation Services Benefit Waiting Period is [[12] [months].]			
[Not Covered]			
	[]Select] Participating Provider Benefits]	**[Participating Provider Benefits / Network Provider Benefits]**	**[Non-[Select] Participating Provider Benefits/ Non-Participating Provider Benefits/ Non-Network Provider Benefits]**
[Repatriation Services]] Maximum [Lifetime] [Calendar Year] [Plan Year] [Benefit Period] [Per Cause] [Monthly] [Daily] Benefit]	[$XXX] [per Covered Person]	[$XXX] [per Covered Person]	[$XXX] [per Covered Person]
[Repatriation Services Deductible] [Individual]	[$XXX]	[$XXX]	[$XXX]
[Integrated] [Family]	[$XXX]	[$XXX]	[$XXX]
[The [Repatriation Services Deductible] does [not] apply to the Plan Deductible or Total Out-of-Pocket Limits.]			
[Once [[2] or more Covered Persons have collectively met] the maximum Family Deductible [[has been met], no additional Deductible will be taken during the [Calendar Year] [Plan Year] [Benefit Period] [Time Period].]			
[Copayment]	[None / $XXX per Repatriation Service]	[None / $XXX per Repatriation Service]	[None / $XXX per Repatriation Service]
[[Repatriation Services] [Coinsurance] [Tier [1]]	[0% - 100% [until the [Repatriation Services] [Tier [1]] Out-of-Pocket Limits are satisfied; [then Tier [2];] [100% thereafter.]]	[0% - 100% [until the [Repatriation Services] [Tier [1]] Out-of-Pocket Limits are satisfied; [then Tier [2];] [100%	[0% - 100% [until the [Repatriation Services] [Tier [1]] Out-of-Pocket Limits are satisfied; [then Tier [2];] [100% thereafter.]]

		thereafter.]]	
[Tier [1]] [[Repatriation Services]Out-of-Pocket Limit [each [Calendar Year] [Benefit Period] [Time Period] [Plan Year]] [Individual] [Family]	[$0 - $25,000 / Not applicable] [$0 - $75,000 / Not applicable]	[$0 - $25,000 / Not applicable] [$0 - $75,000 / Not applicable]	[$0 - $25,000 / an additional $0 - $10,000] [$0 - $75,000 / an additional $0 - $30,000]
[[Repatriation Services] [Coinsurance] [Tier [2]]	[0% - 100% [until the [Repatriation Services] [Tier [2]] Out-of-Pocket Limits are satisfied; [then Tier [X];] [100% thereafter.]]	[0% - 100% [until the [Repatriation Services] [Tier [2]] Out-of-Pocket Limits are satisfied; [then Tier [X];] [100% thereafter.]]	[0% - 100% [until the [Repatriation Services] [Tier [2]] Out-of-Pocket Limits are satisfied; [then Tier [X];] [100% thereafter.]]
[Tier [2]] [[Repatriation Services]Out-of-Pocket Limit [each [Calendar Year] [Benefit Period] [Time Period] [Plan Year]] [Individual] [Family]	[$0 - $25,000 / Not applicable] [$0 - $75,000 / Not applicable]	[$0 - $25,000 / Not applicable] [$0 - $75,000 / Not applicable]	[$0 - $25,000 / an additional $0 - $10,000] [$0 - $75,000 / an additional $0 - $30,000]
[[Repatriation Services] [Coinsurance] [Tier [X]]	[0% - 100% [until the [Repatriation Services] [Tier [X]] Out-of-Pocket Limits are satisfied;] [then Tier [X + [1]];] [100% thereafter.]]	[0% - 100% [until the [Repatriation Services] [Tier [X]] Out-of-Pocket Limits are satisfied;] [then Tier [X + [1]];] [100% thereafter.]]	[0% - 100% [until the [Repatriation Services] [Tier [X]] Out-of-Pocket Limits are satisfied;] [then Tier [X + [1]];] [100% thereafter.]]
[Tier [X]] [[Repatriation Services]Out-of-Pocket Limit [each [Calendar Year] [Benefit Period] [Time Period] [Plan Year]] [Individual] [Family]	[$0 - $25,000 / Not applicable] [$0 - $75,000 / Not applicable]	[$0 - $25,000 / Not applicable] [$0 - $75,000 / Not applicable]	[$0 - $25,000 / an additional $0 - $10,000] [$0 - $75,000 / an additional $0 - $30,000]
[[Repatriation Services] [Out-of-Pocket Limits]] [Individual]	[$XXX]	[$XXX]	[$XXX]

[Family]	[$XXX]	[$XXX]	[$XXX]
[Benefits for [Repatriation Services] are payable at [0%-100%] [with a [$10 - $100] Copayment] when a [Designated Specialty Service Provider] is used. If a [Designated Specialty Service Provider] is not used, [Covered Charges will be [paid at the [Non-][Participating] [or] [applicable] Coinsurance] [reduced by [$1 - $3,000] [1%-50%]] [limited to [$XXX] per [Calendar] [Plan] Year] [per Covered Person] [after the Covered Person has paid any applicable Copayment, Deductible or other fees.] [These limitations will apply to all treatment rendered by a provider that is not designated as a [Designated Specialty Service Provider] regardless of whether the provider is a [Network Provider,] [Participating Provider,] [or] [Select Participating Provider].]			

BEN: 275.001.GE

[Medical Evacuation Services:]			
[All services, supplies and treatments apply to the [Outpatient] [and] [Calendar Year] [and] [Plan Year] [Benefit Period] [Per Cause] Maximum Benefit]			
[Subject to [Plan] [and] [Outpatient] [Integrated] [Per Cause] Deductible] and [Plan] [and] [Outpatient] Coinsurance [unless otherwise specified]]			
[Benefits for Medical Evacuation Services are limited to a Maximum [Lifetime] [Calendar Year] [Plan Year] [Benefit Period] [Per Cause] [Monthly] [Daily] Benefit of [$XXX]]			
[Benefits for Medical Evacuation Services are limited to a Maximum Benefit of [[$10,000] [per Covered Person].]			
[Medical Evacuation Services Benefit Waiting Period is [[12] [months].]			
[Not Covered]			
	[[Select] Participating Provider Benefits]	**[Participating Provider Benefits / Network Provider Benefits]**	**[Non-[Select] Participating Provider Benefits/ Non-Participating Provider Benefits/ Non-Network Provider Benefits]**
[Medical Evacuation Services]] Maximum [Lifetime] [Calendar Year] [Plan Year] [Benefit Period] [Per Cause] [Monthly] [Daily] Benefit]	[$XXX] [per Covered Person]	[$XXX] [per Covered Person]	[$XXX] [per Covered Person]
[Medical Evacuation Services Deductible] [Individual] [Integrated] [Family]	[$XXX] [$XXX]	[$XXX] [$XXX]	[$XXX] [$XXX]
[The [Medical Evacuation Services Deductible] does [not] apply to the Plan Deductible or Total Out-of-Pocket Limits.]			
[Once [[2] or more Covered Persons have collectively met] the maximum Family Deductible [[has been met], no additional Deductible will be taken during the [Calendar Year] [Plan Year] [Benefit Period] [Time Period].]			
[Copayment]	[None / $XXX per Medical Evacuation Service]	[None / $XXX per Medical Evacuation Service]	[None / $XXX per Medical Evacuation Service]
[[Medical Evacuation Services] [Coinsurance] [Tier [1]]	[0% - 100% [until the [Medical Evacuation Services] [Tier [1]] Out-of-Pocket Limits are satisfied; [then Tier [2];] [100% thereafter.]]	[0% - 100% [until the [Medical Evacuation Services] [Tier [1]] Out-of-Pocket Limits are satisfied; [then Tier [2];] [100% thereafter.]]	[0% - 100% [until the [Medical Evacuation Services] [Tier [1]] Out-of-Pocket Limits are satisfied; [then Tier [2];] [100% thereafter.]]

[Tier [1]] [[Medical Evacuation Services]Out-of-Pocket Limit [each [Calendar Year] [Benefit Period] [Time Period] [Plan Year]] [Individual] [Family]	[$0 - $25,000 / Not applicable] [$0 - $75,000 / Not applicable]	[$0 - $25,000 / Not applicable] [$0 - $75,000 / Not applicable]	[$0 - $25,000 / an additional $0 - $10,000] [$0 - $75,000 / an additional $0 - $30,000]
[[Medical Evacuation Services] [Coinsurance] [Tier [2]]	[0% - 100% [until the [Medical Evacuation Services] [Tier [2]] Out-of-Pocket Limits are satisfied; [then Tier [X];] [100% thereafter.]]	[0% - 100% [until the [Medical Evacuation Services] [Tier [2]] Out-of-Pocket Limits are satisfied; [then Tier [X];] [100% thereafter.]]	[0% - 100% [until the [Medical Evacuation Services] [Tier [2]] Out-of-Pocket Limits are satisfied; [then Tier [X];] [100% thereafter.]]
[Tier [2]] [[Medical Evacuation Services]Out-of-Pocket Limit [each [Calendar Year] [Benefit Period] [Time Period] [Plan Year]] [Individual] [Family]	[$0 - $25,000 / Not applicable] [$0 - $75,000 / Not applicable]	[$0 - $25,000 / Not applicable] [$0 - $75,000 / Not applicable]	[$0 - $25,000 / an additional $0 - $10,000] [$0 - $75,000 / an additional $0 - $30,000]
[[Medical Evacuation Services] [Coinsurance] [Tier [X]]	[0% - 100% [until the [Medical Evacuation Services] [Tier [X]] Out-of-Pocket Limits are satisfied;] [then Tier [X + [1]];] [100% thereafter.]]	[0% - 100% [until the [Medical Evacuation Services] [Tier [X]] Out-of-Pocket Limits are satisfied;] [then Tier [X + [1]];] [100% thereafter.]]	[0% - 100% [until the [Medical Evacuation Services] [Tier [X]] Out-of-Pocket Limits are satisfied;] [then Tier [X + [1]];] [100% thereafter.]]
[Tier [X]] [[Medical Evacuation Services]Out-of-Pocket Limit [each [Calendar Year] [Benefit Period] [Time Period] [Plan Year]] [Individual] [Family]	[$0 - $25,000 / Not applicable] [$0 - $75,000 / Not applicable]	[$0 - $25,000 / Not applicable] [$0 - $75,000 / Not applicable]	[$0 - $25,000 / an additional $0 - $10,000] [$0 - $75,000 / an additional $0 - $30,000]
[[Medical Evacuation Services] [Out-of-Pocket Limits]] [Individual] [Family]	[$XXX] [$XXX]	[$XXX] [$XXX]	[$XXX] [$XXX]

[Benefits for [Medical Evacuation Services] are payable at [0%-100%] [with a [$10 - $100] Copayment] when a [Designated Specialty Service Provider] is used. If a [Designated Specialty Service Provider] is not used, [Covered Charges will be [paid at the [Non-][Participating] [or] [applicable] Coinsurance] [reduced by [$1 - $3,000] [1%-50%]] [limited to [$XXX] per [Calendar] [Plan] Year] [per Covered Person] [after the Covered Person has paid any applicable Copayment, Deductible or other fees.] [These limitations will apply to all treatment rendered by a provider that is not designated as a [Designated Specialty Service Provider] regardless of whether the provider is a [Network Provider,] [Participating Provider,] [or] [Select Participating Provider].]

BEN: 280.001.GE

[**Outpatient] Prescription Drug Benefits**:]
[All services, supplies and treatments apply to the [Outpatient] [and] [Calendar Year] [Plan Year] Maximum Benefit]
[Subject to [Plan][and][Outpatient][Integrated] [Per Cause] Deductible] and [Plan][and][Outpatient] Coinsurance [unless otherwise specified]]
[Benefits for Prescription Drugs are limited to a Maximum [Calendar Year] [Plan Year] [Monthly] [Daily] Benefit of [$1,000 - $10,000~~$2,000~~] [per] [Covered Person] [Covered Child] [$2,000 - $20,000~~$10,000~~] [per Family]]
[Benefits for Prescription Drugs are limited to a Maximum [Lifetime] [Benefit Period] Benefit of [$1,000 - $10,000~~$2,000~~] [per] [Covered Person] [Covered Child] [$2,000 - $20,000~~$10,000~~] [per Family]]
[For Prescription Drugs and medicines Covered Charges are limited to [$2,000] per [Calendar Year][Plan Year][Benefit Period] [Time Period] for: • [Legend drugs and medicines that by Federal law can only be obtained with a prescription;] • [Injectable insulin with a prescription;] • [Disposable insulin syringes, and disposable blood/urine, glucose/acetone testing agents or lancets.]]
[[$20] maximum per [Outpatient] Prescription Drug[, limited to $1,000 - $5,000~~$2,000~~] [limited to [XX] prescriptions] Maximum Benefit per [Calendar Year][Plan Year][Benefit Period] [Time Period] [Month][for] [Anti-Infective Prescription Drugs] [per Covered Person] [Per Covered Child]]
[[Outpatient] Prescription Drugs Benefit Waiting Period is [[12] months] [[365] days].]
[Outpatient] Prescription Drugs Benefits do [not] apply to the [Plan][Inpatient][Outpatient] Out of Pocket Limits]
[Not Covered]
[Participating Pharmacy Plan:] [PBM]
[Prescription Drug [Calendar Year] [Plan Year] [Benefit Period] [Per Cause] Maximum Benefit] [[$XXX] per [Covered Person] [Covered Child]]: [[Preferred][Generic] Drug: [$100 - $5]] [[Non-preferred][Generic] Drug: [$100 - $5,000]] [[Preferred] Brand Name Drug: [$100 - $5,000]] [[Non-Preferred] Brand Name Drug: [$100 - $5,000]]
[Prescription Drug [Lifetime] Maximum Benefit] [[$XXX] [per Covered Person] [Covered Child]]: [[Preferred][Generic] Drug: [$100 - $5,000]] [[Non-preferred][Generic] Drug: [$100 - $5,000]] [[Preferred] Brand Name Drug: [$100 - $5,000]] [[Non-Preferred] Brand Name Drug: [$100 - $5,000]]
[Prescription Drug [Individual] [Integrated] Deductible:] [$0 - $9750] [[Preferred][Generic] Drug: [$0 - $9750]] [[Non-Preferred] Generic Drug: [$0 - $9750]] [[Preferred] Brand Name Drug: [$0 - $9750]] [[Non-Preferred] Brand Name Drug: [$0 - $9750]] [Subject to Plan [Individual] Deductible and Coinsurance.] **[Prescription Drug [Integrated] Family Maximum Deductible:]** [$0 - $9750] [[Preferred][Generic] Drug: [$0 - $9750]] [[Non-preferred] Generic Drug: [$0 - $9750]] [[Preferred] Brand Name Drug: [$0 - $9750]] [[Non-Preferred] Brand Name Drug: [$0 - $9750]] [Subject to [Integrated] [Family] Deductible and Coinsurance.]

[Prescription Drug [Deductible] [per Covered Person] [Covered Child]:] [$0 - $9750]

[**Designated Specialty Pharmacy Provider**] **Deductible**:] [$0 - $9750]
[[Preferred][Generic] Drug: [$0 - $9750]]
[[Non-preferred] Generic Drug: [$0 - $9750]]
[[Preferred] Brand Name Drug: [$0 - $9750]]
[[Non-Preferred] Brand Name Drug: [$0 - $9750]]
[Subject to [Plan] [Integrated] [Family] Deductible and Coinsurance.]

[**Participating Pharmacy**] **Deductible**:] [$0 - $9750]
[[Preferred][Generic] Drug: [$0 - $9750]]
[[Non-preferred] Generic Drug: [$0 - $9750]]
[[Preferred] Brand Name Drug: [$0 - $9750]]
[[Non-Preferred] Brand Name Drug: [$0 - $9750]]
[Subject to [Plan] [Integrated] [Family] Deductible and Coinsurance.]

[**Non-Participating Pharmacy**] **Deductible**:] [$0 - $9750]
[[Preferred][Generic] Drug: [$0 - $9750]]
[[Non-preferred] Generic Drug: [$0 - $9750]]
[[Preferred] Brand Name Drug: [$0 - $9750]]
[[Non-Preferred] Brand Name Drug: [$0 - $9750]]
[Subject to [Plan] [Integrated] [Family] Deductible and Coinsurance.]

[**Mail Service Prescription Drug [Individual] [Integrated] Deductible**:] [$0 - $9750]
[[Preferred][Generic] Drug: [$0 - $9750]]
[[Non-Preferred] Generic Drug: [$0 - $9750]]
[[Preferred] Brand Name Drug: [$0 - $9750]]
[[Non-Preferred] Brand Name Drug: [$0 - $9750]]
[Subject to Plan [Individual] Deductible and Coinsurance.]

[**Mail Service Prescription Drug [Integrated] Family Maximum Deductible**:] [$0 - $9750]
[[Preferred][Generic] Drug: [$0 - $9750]]
[[Non-preferred] Generic Drug: [$0 - $9750]]
[[Preferred] Brand Name Drug: [$0 - $9750]]
[[Non-Preferred] Brand Name Drug: [$0 - $9750]]
[Subject to [Integrated] [Family] Deductible and Coinsurance.]

[Tier 1] [Copayment:]

[**Designated Specialty Pharmacy Provider**:] [$0 - $100]
[[Preferred][Generic] Drug: [$0 - $50
[[Non-preferred] Generic Drug: [$1 - $50]]
[[Preferred] Brand Name Drug: [$1-100]]
[[Non-Preferred] Brand Name Drug: [$1-100]]

[**Participating Pharmacy**:] [$0 - $100]
[[Preferred][Generic] Drug: [$0 - $50]]
[[Non-preferred] Generic Drug: [$1 - $50]]
[[Preferred] Brand Name Drug: [$1-100]]
[[Non-Preferred] Brand Name Drug: [$1-100]]

[**Non-Participating Pharmacy**:] [$0 - $100]
[Reimbursed at the Contracted Rates]
[[Preferred] [Generic] Drug: [$0 - $50]]
[[Non-preferred] Generic Drug: [$1 - $50]]
[[Preferred] Brand Name Drug: [$1-100]]
[[Non-Preferred] Brand Name Drug: [$1-100]]

[**Mail Service Prescription Drug Vendor**:] [$0 - $100]
[[Preferred][Generic] Drug: [$0 - $50]]
[[Non-preferred] Generic Drug: [$1 - $50]]
[[Preferred] Brand Name Drug: [$1-100]]
[[Non-Preferred] Brand Name Drug: [$1-100]]

[Tier 1] Coinsurance:

[**Designated Specialty Pharmacy Provider**:] [0% - 100%]
[[Preferred][Generic] Drug: [0% - 100%]]
[[Non-preferred] Generic Drug: [0% - 100%]]
[[Preferred] Brand Name Drug: [0% - 100%]]
[[Non-Preferred] Brand Name Drug: 0% - 100%]]

[**Participating Pharmacy**:] [0% - 100%]
[[Preferred][Generic] Drug: [0% - 100%]]
[[Non-preferred] Generic Drug: [0% - 100%]]
[[Preferred Brand Name Drug: [0% - 100%]]
[[Non-Preferred Brand Name Drug: 0% - 100%]]

[**Non-Participating Pharmacy**:] [0% - 100%]
[Reimbursed at the Contracted Rates]
[[Preferred][Generic] Drug: [0% - 100%]]
[[Non-preferred] Generic Drug: [0% - 100%]]
[[Preferred] Brand Name Drug: [0% - 100%]]
[[Non-Preferred] Brand Name Drug: 0% - 100%]]

[**Mail Service Prescription Drug Vendor**:] [0% - 100%]
[[Preferred][Generic] Drug: [0% - 100%]]
[[Non-preferred] Generic Drug: [0% - 100%]]
[[Preferred] Brand Name Drug: [0% - 100%]]
[[Non-Preferred] Brand Name Drug: 0% - 100%]]

[Tier 1] Out-of-Pocket Limits	**[Individual]**	**[Common][Integrated][Family]**
[**Designated Specialty Pharmacy Provider**]	[$0-$25,000]	[$0-$25,000]
[[Preferred][Generic] Drug:]	[$0-$25,000]	[$0-$25,000]
[[Non-preferred] Generic Drug:]	[$0-$25,000]	[$0-$25,000]
[[Preferred] Brand Name Drug:]	[$0-$25,000]	[$0-$25,000]
[[Non-Preferred] Brand Name Drug:]	[$0-$25,000]	[$0-$25,000]
[**Participating Pharmacy**]	[$0-$25,000]	[$0-$25,000]
[[Preferred][Generic] Drug:]	[$0-$25,000]	[$0-$25,000]
[[Non-preferred] Generic Drug:]	[$0-$25,000]	[$0-$25,000]
[[Preferred Brand Name Drug:]	[$0-$25,000]	[$0-$25,000]
[[Non-Preferred Brand Name:]	[$0-$25,000]	[$0-$25,000]
[**Non-Participating Pharmacy**]	[$0-$25,000]	[$0-$25,000]
[[Preferred][Generic] Drug:]	[$0-$25,000]	[$0-$25,000]
[[Non-preferred] Generic Drug:]	[$0-$25,000]	[$0-$25,000]
[[Preferred] Brand Name Drug:]	[$0-$25,000]	[$0-$25,000]
[[Non-Preferred] Brand Name Drug:]	[$0-$25,000]	[$0-$25,000]
[**Mail Service Prescription Drug Vendor**]	[$0-$25,000]	[$0-$25,000]
[[Preferred][Generic] Drug:]	[$0-$25,000]	[$0-$25,000]
[[Non-preferred] Generic Drug:]	[$0-$25,000]	[$0-$25,000]
[[Preferred] Brand Name Drug:]	[$0-$25,000]	[$0-$25,000]
[[Non-Preferred] Brand Name Drug:]	[$0-$25,000]	[$0-$25,000]

[Tier 2] [Copayment:]

[**Designated Specialty Pharmacy Provider**:] [$0 - $25]
[[Preferred][Generic] Drug: [$0 - $25]]
[[Non-preferred] Generic Drug: [$1 - $25]]
[[Preferred] Brand Name Drug: [$1-75]]
[[Non-Preferred] Brand Name Drug: [$1-75]]
[Subject to [Plan][Integrated][Family] Deductible and Coinsurance.]

[**Participating Pharmacy**:] [$0 - $25]
[[Preferred][Generic] Drug: [$0 - $25]]
[[Non-preferred] Generic Drug: [$1 - $25]]
[[Preferred] Brand Name Drug: [$1-75]]
[[Non-Preferred] Brand Name Drug: [$1-75]]
[Subject to [Plan][Integrated][Family] Deductible and Coinsurance.]

[**Non-Participating Pharmacy**:] [$0 - $25]
[Reimbursed at the Contracted Rates]
[[Preferred] [Generic] Drug: [$0 - $25]]
[[Non-preferred] Generic Drug: [$1 - $25]]
[[Preferred] Brand Name Drug: [$1-75]]
[[Non-Preferred] Brand Name Drug: [$1-75]]
[Subject to [Plan][Integrated][Family] Deductible and Coinsurance.]

[**Mail Service Prescription Drug Vendor**:] [$0 - $25]
[[Preferred][Generic] Drug: [$0 - $25]]
[[Non-preferred] Generic Drug: [$1 - $25]]
[[Preferred] Brand Name Drug: [$1-75]]
[[Non-Preferred] Brand Name Drug: [$1-75]]
[Subject to [Plan][Integrated][Family] Deductible and Coinsurance.]

[Tier 2] Coinsurance

[**Designated Specialty Pharmacy Provider**:] [0% - 100%]
[[Preferred][Generic] Drug: [0% - 100%]]
[[Non-preferred] Generic Drug: [0% - 100%]]
[[Preferred] Brand Name Drug: [0% - 100%]]
[[Non-Preferred] Brand Name Drug: 0% - 100%]]
[No Prescription Drug Coinsurance. Subject to [Plan] Coinsurance.]

[**Participating Pharmacy**:] [0% - 100%]
[[Preferred][Generic] Drug: [0% - 100%]]
[[Non-preferred] Generic Drug: [0% - 100%]]
[[Preferred Brand Name Drug: [0% - 100%]]
[[Non-Preferred Brand Name Drug: 0% - 100%]]
[No Prescription Drug Coinsurance. Subject to [Plan] Coinsurance.]

[**Non-Participating Pharmacy**:] [0% - 100%]
[Reimbursed at the Contracted Rates]
[[Preferred][Generic] Drug: [0% - 100%]]
[[Non-preferred] Generic Drug: [0% - 100%]]
[[Preferred] Brand Name Drug: [0% - 100%]]
[[Non-Preferred] Brand Name Drug: 0% - 100%]]
[No Prescription Drug Coinsurance. Subject to [Plan] Coinsurance.]

[**Mail Service Prescription Drug Vendor**:] [0% - 100%]
[[Preferred][Generic] Drug: [0% - 100%]]
[[Non-preferred] Generic Drug: [0% - 100%]]
[[Preferred] Brand Name Drug: [0% - 100%]]
[[Non-Preferred] Brand Name Drug: 0% - 100%]]
[No Prescription Drug Coinsurance. Subject to [Plan] Coinsurance.]

[Tier 2] Out-of-Pocket Limits	**[Individual]**	**[Common][Integrated][Family]**
[**Designated Specialty Pharmacy Provider**]	[$0-$25,000]	[$0-$25,000]
[[Preferred][Generic] Drug:]	[$0-$25,000]	[$0-$25,000]
[[Non-preferred] Generic Drug:]	[$0-$25,000]	[$0-$25,000]
[[Preferred] Brand Name Drug:]	[$0-$25,000]	[$0-$25,000]
[[Non-Preferred] Brand Name Drug:]	[$0-$25,000]	[$0-$25,000]
[Subject to [Plan] Out-of-Pocket Limits]		
[**Participating Pharmacy**]	[$0-$25,000]	[$0-$25,000]
[[Preferred][Generic] Drug:]	[$0-$25,000]	[$0-$25,000]
[[Non-preferred] Generic Drug:]	[$0-$25,000]	[$0-$25,000]
[[Preferred Brand Name Drug:]	[$0-$25,000]	[$0-$25,000]
[[Non-Preferred Brand Name:]	[$0-$25,000]	[$0-$25,000]
[Subject to [Plan] Out-of-Pocket Limits]		
[**Non-Participating Pharmacy**]	[$0-$25,000]	[$0-$25,000]
[[Preferred][Generic] Drug:]	[$0-$25,000]	[$0-$25,000]
[[Non-preferred] Generic Drug:]	[$0-$25,000]	[$0-$25,000]
[[Preferred] Brand Name Drug:]	[$0-$25,000]	[$0-$25,000]
[[Non-Preferred] Brand Name Drug:]	[$0-$25,000]	[$0-$25,000]
[Subject to [Plan] Out-of-Pocket Limits]		
[**Mail Service Prescription Drug Vendor**]	[$0-$25,000]	[$0-$25,000]
[[Preferred][Generic] Drug:]	[$0-$25,000]	[$0-$25,000]
[[Non-preferred] Generic Drug:]	[$0-$25,000]	[$0-$25,000]
[[Preferred] Brand Name Drug:]	[$0-$25,000]	[$0-$25,000]
[[Non-Preferred] Brand Name Drug:]	[$0-$25,000]	[$0-$25,000]
[Subject to [Plan] Out-of-Pocket Limits]		

[Tier 3] [Copayment:]

[**Designated Specialty Pharmacy Provider**:] [$0 - $25]
[[Preferred][Generic] Drug: [$0 - $25]]
[[Non-preferred] Generic Drug: [$1 - $25]]
[[Preferred] Brand Name Drug: [$1-75]]
[[Non-Preferred] Brand Name Drug: [$1-75]]
[Subject to [Plan] Deductible and Coinsurance.]

[**Participating Pharmacy**:] [$0 - $25]
[[Preferred][Generic] Drug: [$0 - $25]]
[[Non-preferred] Generic Drug: [$1 - $25]]
[[Preferred] Brand Name Drug: [$1-75]]
[[Non-Preferred] Brand Name Drug: [$1-75]]
[Subject to [Plan] Deductible and Coinsurance.]

[**Non-Participating Pharmacy**:] [$0 - $25]
[Reimbursed at the Contracted Rates]
[[Preferred] [Generic] Drug: [$0 - $25]]
[[Non-preferred] Generic Drug: [$1 - $25]]
[[Preferred] Brand Name Drug: [$1-75]]
[[Non-Preferred] Brand Name Drug: [$1-75]]
[Subject to [Plan] Deductible and Coinsurance.]

[**Mail Service Prescription Drug Vendor**:] [$0 - $25]
[[Preferred][Generic] Drug: [$0 - $25]]
[[Non-preferred] Generic Drug: [$1 - $25]]
[[Preferred] Brand Name Drug: [$1-75]]
[[Non-Preferred] Brand Name Drug: [$1-75]]
[Subject to [Plan] Deductible and Coinsurance.]

[Tier 3] Coinsurance

[**Designated Specialty Pharmacy Provider**:] [0% - 100%]
[[Preferred][Generic] Drug: [0% - 100%]]
[[Non-preferred] Generic Drug: [0% - 100%]]
[[Preferred] Brand Name Drug: [0% - 100%]]
[[Non-Preferred] Brand Name Drug: 0% - 100%]]
[No Prescription Drug Coinsurance. Subject to [Plan] Coinsurance.]

[**Participating Pharmacy**:] [0% - 100%]
[[Preferred][Generic] Drug: [0% - 100%]]
[[Non-preferred] Generic Drug: [0% - 100%]]
[[Preferred Brand Name Drug: [0% - 100%]]
[[Non-Preferred Brand Name Drug: 0% - 100%]]
[No Prescription Drug Coinsurance. Subject to [Plan] Coinsurance.]

[**Non-Participating Pharmacy**:] [0% - 100%]
[Reimbursed at the Contracted Rates]
[[Preferred][Generic] Drug: [0% - 100%]]
[[Non-preferred] Generic Drug: [0% - 100%]]
[[Preferred] Brand Name Drug: [0% - 100%]]
[[Non-Preferred] Brand Name Drug: 0% - 100%]]
[No Prescription Drug Coinsurance. Subject to [Plan] Coinsurance.]

[**Mail Service Prescription Drug Vendor**:] [0% - 100%]
[[Preferred][Generic] Drug: [0% - 100%]]
[[Non-preferred] Generic Drug: [0% - 100%]]
[[Preferred] Brand Name Drug: [0% - 100%]]
[[Non-Preferred] Brand Name Drug: 0% - 100%]]
[No Prescription Drug Coinsurance. Subject to [Plan] Coinsurance.]

[Tier 3] Out-of-Pocket Limits	**[Individual]**	**[Common][Integrated][Family]**
[**Designated Specialty Pharmacy Provider**]	[$0-$25,000]	[$0-$25,000]
[[Preferred][Generic] Drug:]	[$0-$25,000]	[$0-$25,000]
[[Non-preferred] Generic Drug:]	[$0-$25,000]	[$0-$25,000]
[[Preferred] Brand Name Drug:]	[$0-$25,000]	[$0-$25,000]
[[Non-Preferred] Brand Name Drug:]	[$0-$25,000]	[$0-$25,000]
[Subject to [Plan] Out-of-Pocket Limits]		
[**Participating Pharmacy**]	[$0-$25,000]	[$0-$25,000]
[[Preferred][Generic] Drug:]	[$0-$25,000]	[$0-$25,000]
[[Non-preferred] Generic Drug:]	[$0-$25,000]	[$0-$25,000]
[[Preferred Brand Name Drug:]	[$0-$25,000]	[$0-$25,000]
[[Non-Preferred Brand Name]	[$0-$25,000]	[$0-$25,000]
[Subject to [Plan] Out-of-Pocket Limits]		
[**Non-Participating Pharmacy**]	[$0-$25,000]	[$0-$25,000]
[[Preferred][Generic] Drug:]	[$0-$25,000]	[$0-$25,000]
[[Non-preferred] Generic Drug:]	[$0-$25,000]	[$0-$25,000]
[[Preferred] Brand Name Drug:]	[$0-$25,000]	[$0-$25,000]
[[Non-Preferred] Brand Name Drug:]	[$0-$25,000]	[$0-$25,000]
[Subject to [Plan] Out-of-Pocket Limits]		
[**Mail Service Prescription Drug Vendor**]	[$0-$25,000]	[$0-$25,000]
[[Preferred][Generic] Drug:]	[$0-$25,000]	[$0-$25,000]
[[Non-preferred] Generic Drug:]	[$0-$25,000]	[$0-$25,000]
[[Preferred] Brand Name Drug:]	[$0-$25,000]	[$0-$25,000]
[[Non-Preferred] Brand Name Drug:]	[$0-$25,000]	[$0-$25,000]
[Subject to [Plan] Out-of-Pocket Limits]		

[[$0-500] [Calendar Year] [Benefit Period] [Per Cause] [Time Period] [Plan Year] [Brand Name Drug] Deductible. [The Deductible applies to [level] [group][1][A][,] [level] [group] [2] [B] [,] [level] [group [3] [C] [and] [level] [group] [4] [D] [and] [level] [group] [5] [E]] [Brand Name] Drugs.]	
[[Therapeutic l] [Class] [1] [a] drugs] [Deductible] [Drugs appearing on the drug list]	[$0 - $9750]
[[Therapeutic l] [Class] [1] [a] drugs] [Drugs appearing on the drug list]	[Not Covered] [$0-$100] [10-100%] [Copayment] [with a minimum Copayment of [$5-50]] [Amounts exceeding [$5-100]]]allowance] [up to a maximum Copayment of [$0-$1000]] [per Prescription or refill.][for the first XX of Prescriptions][then $XX for the next XX of Prescription] [then $XX for subsequent Prescriptions]]
[[Therapeutic l] [Class] [2] [B] drugs] [Deductible]	[$0 - $9750]
[[Therapeutic l] [Class] [2] [B] drugs]	[Not Covered] [$0-$100] [10-100%] [Copayment] [with a minimum Copayment of [$5-50]] [Amounts exceeding [$5-100]]]allowance] [up to a maximum Copayment of [$0-$1000]] [per Prescription or refill].[for the first XX of Prescriptions][then $XX for the next XX of Prescription] [then $XX for subsequent Prescriptions]]
[[Therapeutic l] [Class] [3] [C] drugs] [Deductible]	[$0 - $9750]
[[Therapeutic l] [Class] [3] [C] drugs]	[Not Covered] [$0-$100] [10-100%] [Copayment] [with a minimum Copayment of [$5-50]] [Amounts exceeding [$5-100]]]allowance] [up to a maximum Copayment of [$0-$1000]] [per Prescription or refill].[for the first XX of Prescriptions][then $XX for the next XX of Prescription] [then $XX for subsequent Prescriptions]]
[[Therapeutic l] [Class] [4] [D] drugs] [Deductible]	[$0 - $9750]
[[Therapeutic l] [Class] [4] [D] drugs]	[Not Covered] [$0-$100] [10-100%] [Copayment] [with a minimum Copayment of [$5-50]] [Amounts exceeding [$5-100]]]allowance] [up to a maximum Copayment of [$0-$1000]] [per Prescription or refill].[for the first XX of Prescriptions][then $XX for the next XX of Prescription] [then $XX for subsequent Prescriptions]]

[[Therapeutic l] [Class] [5] [E] drugs] [Deductible]	[$0 - $9750]
[[Therapeutic l] [Class] [5] [E] drugs]	[Not Covered] [$0-$100] [10-100%] [Copayment] [with a minimum Copayment of [$5-50]] [Amounts exceeding [$5-100]]]allowance] [up to a maximum Copayment of [$0-$1000]] [per Prescription or refill].[for the first XX of Prescriptions][then $XX for the next XX of Prescription] [then $XX for subsequent Prescriptions]]

BEN: 220.001.001.GE

[**Life Insurance**:]

[Certificate Holder	$[0-250,000]]
[Covered Dependent Spouse	$[0-250,000]]
[Covered Dependent Child(ren)	$[0-50,000]]

[This Amount of Life Insurance will be subject to the Age Reduction Percentages listed below:]

[Age Reduction Percentages:]

[Reduction Age:]	[Reduction Percentage:]
[[55]	Reduces to [70]% of the amount in force immediately prior to age [55]]
[[65]	Reduces to [60]% of the amount in force immediately prior to age [65]]
[[70]	Reduces to [60]% of the amount in force immediately prior to age [70]]

BEN: 225.001.GE

[**Accelerated Benefit**:]

[[Up to] [50%] of the Life Insurance Benefit.]

BEN: 230.001.GE

[**Accidental Death & Dismemberment Insurance**[**for Employee**]:]

[The Accidental Death Benefit will be] [[an amount equal to] [and in addition to]] the amount of Life Insurance [(including any applicable adjustment or reduction)] in effect on the date of loss.]

[Certificate Holder	$[10,000] [2X's] [3X's]]
[Dependent Covered Spouse	$[5,000] [2X's] [3X's]]
[Dependent Covered Child(ren)	$[2,000] [2X's] [3X's]]

BEN: 235.001.GE

Time Insurance Company
501 West Michigan
Milwaukee, WI 53203

CERTIFICATE AMENDMENT RIDER (05/2008)

The following amendments will be incorporated into the certificate of medical insurance (form TIM.CER.AR, which was previously approved by your Department on October 25, 2005).

The bulleted headers (in bold/italics) will identify if the language will be added, removed or replaced/modified.

FORM TIM.CER.AR AMENDMENTS:

- ***DEF: 155.003.GE is replaced with DEF: 155.003.001.GE, which reads as follows:***

[**Dependent**
A Dependent is:

[1.] The Certificate Holder's lawful spouse[, including the Certificate Holder's Domestic Partner] [if recognized under applicable law]; or

[2.] [The Certificate Holder's naturally born child, legally adopted child, a child that is placed for adoption with the Certificate Holder, a stepchild or a child for which the Certificate Holder is the legal guardian:

[a.] [Who is unmarried; and]
[b.] [Who is age [18] or younger; and]
[c.] [Who is claimed as an exemption on Your most recent federal income tax return, except for a Dependent child who is a full-time student; and]
[d.] [Whose legal address is the same as the Certificate Holder's legal address].]

[If the child's legal address is different than the Certificate Holder, the child will be considered a Dependent if You submit proof that:

[a.] [You are required by a qualified medical child support order to provide medical insurance; or]
[b.] [The child was claimed as an exemption on Your most recent federal income tax return].]

[If Your unmarried child is age [19] or older, the child will be considered a Dependent if You give Us proof that:

[a.] [The child is a full-time student at an accredited educational institution, college or university. A student will be considered full-time if the student meets the standards for full-time status at the school the student is attending. A student will be considered full-time during regular vacation periods that interrupt, but do not terminate, the continuous full-time course of study; or]
[b.] [The child is not capable of self-sustaining employment or engaging in the normal and customary activities of a person of the same age because of mental incapacity or physical handicap. The child must also be chiefly dependent on the Certificate Holder for financial support [and be claimed as an exemption on Your most recent federal income tax return]. You

must give Us proof that the child meets these requirements at the same time that You first enroll for coverage under this plan [or within [31] days after the child reaches the normal age for termination]. Additional proof may be requested periodically [but not more often than annually after the [2-year] period following the date the child reaches the normal age for termination~~]~~.]

[A child will no longer be a Dependent on the earliest of the date that he or she:

[a.] [Is no longer a full-time student; or]
[b.] [Graduates; or]
[c.] [Ceases to be claimed as an exemption on the Certificate Holder's federal income tax return, except for a Dependent child who is a full-time student; or]
[d.] [Attains age [24]; or]
[e.] [Marries; or]
[f.] [Is over age [18] and is capable of self-sustaining employment because he or she is no longer mentally incapacitated or physically handicapped[.][; or]]
[g.] [Or You request their coverage be terminated.]

[This plan terminates in accordance with the Termination Date of Coverage provision.]

[If only Dependent children are covered under this plan, the youngest child will be considered the Certificate Holder. All siblings of the Certificate Holder will be considered Covered Dependents if they meet the requirements above.]]

DEF: 155.003.001.GE

- ***DEF: 155.007.GE is replaced with DEF: 155.007.001.GE, which reads as follows:***

[**Dependent**
A Dependent is:

[1.] [The Certificate Holder's lawful spouse[, including the Certificate Holder's Domestic Partner] [if recognized under applicable law]; or]

[2.] [The Certificate Holder's naturally born child, legally adopted child, a child that is placed for adoption with the Certificate Holder, a stepchild or a child for which the Certificate Holder is the legal guardian:

[a.] [Who is unmarried][; and]
[b.] [Who is chiefly dependent on the Certificate Holder for financial support].]

[A child will no longer be a Dependent on the earliest of the date that~~:~~ ~~he or she:~~

[a.] [He or she ~~M~~marries][;] ~~or]~~

[b.] [He or she ~~I~~is no longer chiefly dependent on the Certificate Holder for financial support]~~.~~[; or]
[c.] [He or she or the Certificate Holder request their coverage be terminated.]]

[This plan terminates in accordance with the Termination Date of Coverage provision.]

[If only Dependent children are covered under this plan, the youngest child will be considered the Certificate Holder. All siblings of the Certificate Holder will be considered Covered Dependents if they meet the requirements above.]]
DEF: 155.007.001.GE

- ***DEF: 235.001.GE is replaced with DEF: 235.001.001.GE, which reads as follows:***

[**Experimental or Investigational Services**
Treatment, services, supplies or equipment which, at the time the charges are Incurred, We determine are:

1. Not proven to be of benefit for diagnosis or treatment of a Sickness or an Injury; or

2. Not generally used or recognized by the medical community as safe, effective and appropriate for diagnosis or treatment of a Sickness or an Injury; or

3. In the research or investigational stage, provided or performed in a special setting for research purposes or under a controlled environment or clinical protocol; or

4. Obsolete or ineffective for the treatment of a Sickness or an Injury; or

5. Medications used for non-FDA approved indications and/or dosage regimens.

For any device, drug, or biological product, final approval must have been received to market it by the Food and Drug Administration (FDA) for the particular Sickness or Injury. However, final approval by the FDA is not sufficient to prove that treatment, services or supplies are of proven benefit or appropriate or effective for diagnosis or treatment of a Sickness or an Injury. Any approval granted as an interim step in the FDA regulatory process, such as an investigational device exemption or an investigational new drug exemption, is not sufficient.

Only We can make the determination as to whether charges are for Experimental or Investigational Services based on the following criteria:

1. Once final FDA approval has been granted, the usage of a device for the particular Sickness or Injury for which the device was approved will be recognized as appropriate if:

    a. It is supported by conclusive evidence that exists in clinical studies that are published in generally accepted peer-reviewed medical literature or review articles; and
    b. The FDA has not determined the medical device to be contraindicated for the particular Sickness or Injury for which the device has been prescribed.

2. Once final FDA approval has been granted, the usage of a drug or biological product will be recognized as appropriate for a particular Sickness or Injury if the FDA has not determined the drug or biological product to be contraindicated for the particular Sickness or Injury for which the drug or biological product has been prescribed and the prescribed usage is recognized as appropriate medical treatment by:

   a. The American Medical Association Drug Evaluations; or
   b. The American Hospital Formulary Service Drug Information; or
   ~~c. The United States Pharmacopeia Drug Information; or~~
   ~~d~~c. Conclusive evidence in clinical studies that are published in generally accepted peer-reviewed medical literature or review articles.

3. For any other treatment, services or supplies, conclusive evidence from generally accepted peer-reviewed literature must exist that:

   a. The treatment, services or supplies have a definite positive effect on health outcomes. Such evidence must include well-designed investigations that have been reproduced by non-affiliated authoritative sources, with measurable results, backed up by the positive endorsements of national medical bodies or panels regarding scientific efficacy and rationale; and
   b. Over time, the treatment, services or supplies lead to improvement in health outcomes which show that the beneficial effects outweigh any harmful effects; and
   c. The treatment, services or supplies are at least as effective in improving health outcomes as established technology, or are useable in appropriate clinical contexts in which established technology is not employable.]

DEF: 235.001.001.GE

- ***DEF: 335.008.GE is added:***

[6.] [**Retail Health Clinic:** A facility that meets all of the following requirements:

   [a.] [[Be licensed by] [or] [operate pursuant to] the state in accordance with the laws for the specific services being provided in that facility;]
   [b.] [Be staffed by a Health Care Practitioner in accordance with the laws of that state;]
   [c.] [Is [attached to] [or] [part of] a store or retail facility;]
   [d.] [Is separate from a[n] [Acute Medical Facility [(Hospital)]][, Emergency Room][, Acute Medical Rehabilitation Facility][, Free-Standing Facility][, Skilled Nursing Facility][, Subacute Rehabilitation Facility,] [or] [Urgent Care Facility] [and any Health Care Practitioner's office located therein,] [even when services are performed after normal business hours;]]
   [e.] [Provides general medical treatment or services for a Sickness or Injury[, or provides preventive medicine services,] [on a non-seasonal basis;] [and]
   [f.] [Does not provide room and board or overnight services.]]

DEF: 335.008.GE

- ***DEF: 400.001.GE is replaced with DEF: 400.001.001.GE, which reads as follows:***

[**Office Visit**
A[n in-person] meeting between a Covered Person and a Health Care Practitioner in the Health Care Practitioner's office[, an Acute Medical Facility's Outpatient department,] [a Free-Standing Facility][,] [a

Retail Health Clinic] [or] [an Urgent Care Facility]. During this meeting, the Health Care Practitioner evaluates and manages the Covered Person's Sickness or Injury as defined in the most recent edition of Current Procedural Terminology [or provides preventive medicine services].]
DEF: 400.001.001.GE

- ***DEF: 500.002.GE is replaced with DEF: 500.002.001.GE, which reads as follows:***

[**Pre-Existing Condition**
A Sickness or an Injury and related complications [, not fully disclosed on the [enrollment form]]:

1. For which medical advice, consultation, diagnosis, care or treatment was sought, received or recommended from a provider [or Prescription Drugs were prescribed] during the [24-month] period immediately prior to the Covered Person's Effective Date, regardless of whether the condition was diagnosed, misdiagnosed or not diagnosed; or

2. That produced signs or symptoms during the [24-month] period immediately prior to the Covered Person's Effective Date.

   The signs or symptoms were significant enough to establish manifestation or onset by one of the following tests:

   a. The signs or symptoms reasonably should have allowed or would have allowed one learned in medicine to diagnose the condition; or
   b. The signs or symptoms reasonably should have caused or would have caused an ordinarily prudent person to seek diagnosis or treatment.

   [A pregnancy that exists on the day before the Covered Person's Effective Date will be considered a Pre-Existing Condition.]]
DEF: 500.002.001.GE

- ***PAR: 010.001.GE is replaced with PAR: 010.001.001.GE, which reads as follows:***

[**Methodology Is Subject to Change**
The Maximum Allowable Amount methodologies listed above may be amended or replaced from time to time at Our discretion, without notice. [Our current methodologies can be obtained by calling Our Home Office.]]

[**Using the [Health Care Provider Network] [Participating Provider Network]**
To receive payment at the desired benefit level, You [and Your Covered Dependents] must meet the requirements for using [Network] [Participating] Providers and must comply with all other plan requirements. [IT IS YOUR RESPONSIBILITY to verify that a provider is participating in the [Health Care Provider Network] [Participating Provider Network] [and whether that provider is participating as a [Participating Provider,] [or] [[Select] Participating Provider] [or] [Designated Specialty Provider]] at the time of service.]]

[**Using Designated Specialty Providers**
If the Covered Person elects to receive designated covered specialty services from a Designated Specialty Provider, benefits may be paid at a higher benefit level than when a [Participating Provider] [or] [[Select]

Participating Provider] is used. The benefit level payable when designated specialty treatment, services or supplies are received from a Designated Specialty Provider is shown in the Benefit Summary. For the Designated Specialty Provider benefit level to be payable, both the service and the provider must be designated by Us at the specialty services benefit level. IT IS YOUR RESPONSIBILITY to verify that a provider is a Designated Specialty Provider at the time of service and that the services to be received are designated as specialty services from that provider.]

[**Using Network Facilities**
Even when the Covered Person receives treatment, services or supplies from a network facility, the care may be administered by [Non-Network] [Non-Participating] Providers. IT IS YOUR RESPONSIBILITY to verify that a provider is a [Network] [Participating] Provider at the time of service.]

[**Receiving Care for Emergency Conditions**
Covered Charges for [Non-Network] [Non-Participating] Provider Emergency Treatment[, Urgent Care] and Emergency Confinement will be paid at the Participating Provider benefit level until the Covered Person's condition has stabilized. After the condition has stabilized, benefits will be paid at the [Non-Network] [Non-Participating] Provider benefit level. We will, if possible, assist in the Covered Person's transfer to a [Network] [Participating] Provider if requested by the Covered Person. [Covered Charges for [Non-Network] [Non-Participating] Provider Emergency Treatment[, Urgent Care] and Emergency Confinement may be subject to Maximum Allowable Amount reductions.]]

[**Receiving Ancillary Services**
Please note that certain ancillary services, such as lab tests or services performed by anesthesiologists, radiologists, pathologists or Emergency Room physicians, that are ordered by a [Network] [Participating] Provider are sometimes out-sourced to a [Non-Network] [Non-Participating] Provider. [Covered Charges for such services will be processed as [Non-Network] [Non-Participating] Provider benefits.] [To obtain [Network] [Participating] Provider benefits, it is important that such services be referred to another [Network] [Participating] Provider when possible.] [[Covered Charges for such services rendered in association with direct treatment from a [Network] [Participating] Provider will be paid at the corresponding benefit level].] [and may be subject to the Maximum Allowable Amounts for [Network] [Participating] Providers and Maximum Allowable Amounts for [[Non-Network] [Non-Participating]] Providers provisions.]] [A higher benefit level may be available if the Covered Person uses a Designated Specialty Provider for ancillary services that are designated by Us to be specialty services from that provider.]]]
PAR: 010.001.001.GE

- ***MED: 065.001.GE is replaced with MED: 065.001.001.GE, which reads as follows:***

[**Outpatient Physical Medicine Services**
[Services provided [in the Outpatient department of an Acute Medical Facility,] [by a licensed therapist,] [or] [by a licensed or certified agency in a Covered Person's home] [or] [on an Outpatient basis] that include, but are not limited to:]

[1.] [Physical Therapy, Occupational Therapy and Speech Therapy.]

[2.] [Pulmonary rehabilitation programs.]

[3.] [Adjustments[, and] manipulations [and] [massage therapy].]

[4.] [Cardiac Rehabilitation Programs.]

[5.] [Services for treatment of Developmental Delay.]

Coverage for Outpatient Physical Medicine services will cease when measurable and significant progress toward expected and reasonable outcomes has been achieved or has plateaued as determined by Us.

For laboratory services and Diagnostic Imaging services benefits, see the Diagnostic Imaging Services and Laboratory Services provision in this section.]
MED: 065.001.001.GE

- ***MED: 075.001.GE is replaced with MED: 075.001.001.GE, which reads as follows:***

[**Durable Medical Equipment and Personal Medical Equipment**

[1.] [Rental or purchase, whichever is most cost effective as determined by Us, of the following items when prescribed by a Health Care Practitioner:]

[a.] [A ~~standard non-motorized~~ wheelchair.]
[b.] [A basic Acute Medical Facility bed.]
[c.] [Basic crutches.]

[2.] [Casts, splints, trusses and orthopedic braces, excluding foot orthotics.]

[3.] [The [temporary interim and] initial permanent basic artificial limb or eye.]

[4.] [External breast prostheses needed because of surgical removal of all or part of the breast.]

[5.] [Oxygen and the equipment needed for the administration of oxygen.]

[6.] [Other Durable Medical Equipment and supplies that are approved in advance by Us.]

[Charges for replacement of or maintenance, repair, modification or enhancement to the whole or parts of wheelchairs will be covered when authorized by Us before any equipment is purchased.] [Charges for replacement of or maintenance, repair, modification or enhancement to the whole or parts of any of the items listed above, other than wheelchairs, are not covered, regardless of when the item was originally purchased.] [Replacements due to outgrowing [wheelchairs] [and] [or] Durable [or Personal] Medical Equipment] as a result of the normal skeletal growth of a child will be covered when authorized by Us before any equipment is purchased.] [Charges for duplicate [wheelchairs] [and] [or] Durable Medical Equipment, Personal Medical Equipment and supplies are not covered.]]
MED: 075.001.001.GE

- ***MED: 275.001.GE is added:***

[Repatriation Services
Covered Charges are for the preparation and transportation of a Covered Person's remains to his or her home country or [country] [state] of regular domicile should the Covered Person die while covered under this plan[, provided treatment of the Illness or Injury that caused the Covered Person's death would have

been covered under this plan had the person not died]. If applicable, such action will be in accordance with any international transportation requirements.

[Repatriation must be authorized by Us in advanced before the remains are prepared for transportation.] [No benefits will be paid for transportation expenses of anyone accompanying the body.]]
MED: 275.001.GE

- ***DEF: 280.001.GE is added:***

[**Medical Evacuation Services**:
Covered Charges are for the Covered Person's Medically Necessary evacuation to his or her home country or to a facility operated pursuant to the laws of his or her home country for the treatment of a Sickness or Injury, should the Covered Person be admitted on an Inpatient basis to [an Acute Behavioral Health Inpatient Facility,] an Acute Medical Facility or other licensed facility as a result of a Sickness or Injury.

[Medical Evacuation must be [authorized by Us in advance before the Covered Person is evacuated] [and] [approved by the attending Health Care Practitioner]. [Except as specifically provided herein, no benefits will be provided for charges Incurred outside of the United States or its possessions [or Canada].]]
MED: 280.001.GE

- ***RXP: 005.002.GE is replaced with RXP: 005.002.001.GE, which reads as follows:***

[[VIII.] [OUTPATIENT PRESCRIPTION DRUG BENEFITS]

[ONLY THE PRESCRIPTION DRUGS LISTED AS OUTPATIENT PRESCRIPTION DRUG BENEFITS IN THIS SECTION OF THE PLAN WILL BE CONSIDERED COVERED CHARGES. HOW COVERED CHARGES ARE PAID AND THE MAXIMUM BENEFIT FOR THE COVERED PRESCRIPTION DRUGS LISTED IN THIS SECTION ARE SHOWN IN THE BENEFIT SUMMARY. REFER TO THE EXCLUSIONS SECTION OF THE PLAN FOR DRUGS, MEDICATIONS AND SUPPLIES THAT ARE NOT COVERED UNDER THIS PLAN.

[THE COVERED PERSON MUST FOLLOW THE UTILIZATION REVIEW PROVISIONS SECTION [AND USE THE PARTICIPATING PHARMACY NETWORK] [OR SPECIALTY PHARMACY NETWORK] TO RECEIVE THE MAXIMUM BENEFITS AVAILABLE UNDER THIS PLAN.]

[PRIOR AUTHORIZATION MAY BE REQUIRED FOR CERTAIN PRESCRIPTION DRUGS BEFORE THEY ARE CONSIDERED FOR COVERAGE UNDER THE OUTPATIENT PRESCRIPTION DRUG BENEFITS SECTION. PLEASE ACCESS THE WEBSITE LISTED ON THE BACK OF THE IDENTIFICATION (ID) CARD TO RECEIVE INFORMATION ON WHICH PRESCRIPTION DRUGS REQUIRE PRIOR AUTHORIZATION, TO CHECK PRESCRIPTION DRUG COVERAGE AND PRICING OR TO LOCATE A PARTICIPATING PHARMACY.]]

[After the Covered Person has paid any [Ancillary Charge,] [Ancillary Pharmacy Network Charge,] [Coinsurance,] [Copayment,] [Deductible] or any other applicable fees, benefits will be paid by Us for Covered Charges for Outpatient Prescription Drugs listed in this section of the plan. Any applicable [Coinsurance,] [Copayment,] [Deductible] or other fees [and the Prescription Drug Class] [and] [time period] [Plan Year] [Calendar Year] [Benefit Period] [to which they apply] are shown in the Benefit Summary. Benefits paid under this section will be applied to the Maximum Lifetime Benefit and are also subject to

any other maximum benefit for Prescription Drugs provided under this plan. Benefits are subject to all the terms, limits and conditions in this plan.]

[Any [Ancillary Charge] [or] [any Ancillary Pharmacy Network Charge] under this section will not count toward satisfying any [Access Fee,] [Coinsurance,] [Copayment,] [Deductible] [or] [Out-of-Pocket Limit] under the medical section or any other section in this plan.]

[After the Covered Person has paid any [Ancillary Charge,] [and] [or] [Ancillary Pharmacy Network Charge,] [and] [or] [Prescription Drug Coinsurance,] [and] [or] [Prescription Drug Copayment,] [and] [or] [Prescription Drug Deductible] or any other applicable fees, benefits will be paid by Us for Covered Charges for Outpatient Prescription Drugs listed in this section of the plan.] [Any applicable [Prescription Drug Coinsurance,] [and] [or] [Prescription Drug Copayment,] [and] [or] [Prescription Drug Deductible] or other fees [and the Prescription Drug Class] [and] [time period] [Plan Year] [Calendar Year] [Benefit Period] [to which they apply] are shown in the Benefit Summary.] [Benefits paid under this section will be applied to the Maximum Lifetime Benefit and are also subject to any other maximum benefit for Prescription Drugs provided under this plan. Benefits are subject to all the terms, limits and conditions in this plan.]]

[Any [Ancillary Charge,] [and] [or] [Ancillary Pharmacy Network Charge,] [and] [or] [Prescription Drug Coinsurance,] [and] [or] [Prescription Drug Copayment,] [and] [or] [Prescription Drug Deductible,] under this section will not count toward satisfying any [Access Fee,] [and] [or] [Coinsurance,] [and] [or] [Copayment,] [and] [or] [Deductible] [and] [or] [Out-of-Pocket Limit] under the medical section or any other section in this plan.]

[Unless a Prescription Drug is specifically listed as a Covered Charge in the Medical Benefits section, all Prescription Drugs that are received on an Outpatient basis are considered for benefits under the Outpatient Prescription Drug Benefits section.] [Any amount in excess of the maximum amount provided under this section is not covered under any other section of this plan.] [Expenses Incurred under this section do [not] apply toward any Out-of-Pocket Limits under any other section of this plan.]

[A Prescription Drug must be dispensed through a [Participating Pharmacy] [or Specialty Pharmacy Provider] to receive benefits.] [Prescription Maintenance Drugs must be dispensed through a Mail Service Prescription Drug Vendor to receive benefits.] [Certain Prescription Drugs may be covered under this plan only if they are dispensed through a Specialty Pharmacy Provider.] [These limitations will be shown in the Benefit Summary.]

[This plan provides benefits only for the following Covered Charges for [Prescription] [Generic] Drugs that are received on an Outpatient basis [and dispensed through a] [Participating Pharmacy] [or Specialty Pharmacy Provider] [as shown in the Benefit Summary]:

[1.] [[Prescription] [Generic] Drugs that are fully approved by the U.S. Food and Drug Administration (FDA) for marketing in the United States and can be obtained only with a Prescription Order from a Health Care Practitioner.]

[2.] [[Prescription] [Generic] Drugs that are listed in Our Drug List.]

[3.] [[Up to a] [15 consecutive day] supply for each Prescription Order, unless restricted to a lesser amount by the Prescription Order, the manufacturers' packaging or any limitations in this plan. [If a Mail Service Prescription Drug Vendor is used, We will pay [up to a] [90 consecutive day] supply for

each Prescription Order for Prescription Maintenance Drugs covered by and through the Mail Service Prescription Drug Vendor, unless restricted to a lesser amount by the Prescription Order, the manufacturer's packaging, additional dispensing limitations or other limitations in this plan.]]

[4.] [[Up to] [3 vials] [or] [up to a] [15 consecutive day] supply of one type of self-injectable insulin for each Prescription Order[, whichever is less]. [If a Mail Service Prescription Drug Vendor is used, We will pay [up to] [9 vials] [or] [up to a] [90 consecutive day] supply of one type of self-injectable insulin for each Prescription Order[, whichever is less].]]

[5.] [[Up to] [100] disposable insulin syringes and needles[, up to] [100] disposable blood/urine/glucose/acetone testing agents[, or] [up to] [100] lancets[, or] [up to a] [15 consecutive day] supply for each Prescription Order[, whichever is less]. [If a Mail Service Prescription Drug Vendor is used, We will pay [up to] [300] disposable insulin syringes and needles [or] [up to] [300] disposable blood/urine/glucose/acetone testing agents [or] [up to] [300] lancets[, or] [up to a] [90 consecutive day] supply for each Prescription Order[, whichever is less].]]

[6.] [Prescription Maintenance Drugs that are dispensed through a Mail Service Prescription Drug Vendor. We will pay for the following:

[a.] [Up to] [9 vials] [or] [up to a] [90 consecutive day] supply of one type of self-injectable insulin for each Prescription Order[, whichever is less].]

[b.] [Up to] [300] disposable insulin syringes and needles [or] [up to] [300] disposable blood/urine/glucose/acetone testing agents [or] [up to] [300] lancets[, or] [up to a] [90 consecutive day] supply for each Prescription Order[, whichever is less].]

[c.] [Up to a] [90 consecutive day] supply for each Prescription Order for Prescription Maintenance Drugs, unless restricted to a lesser amount by the Prescription Order, the manufacturer's packaging, additional dispensing limitations or other limitations in this plan.]]

[7.] [[Prescription] [Generic] Drugs, in dosages, dosage forms, dosage regimens and durations of treatment that are Medically Necessary for the treatment of a Sickness or an Injury that is covered under this plan.]

[8.] [[Prescription] [Generic] Drugs that are within the quantity, supply, cost-sharing or other limits that We determine are appropriate for a [Prescription] [Generic] Drug [or within a Therapeutic Class based on the Prescription Drug Class].]

[9.] [[Prescription] [Generic] Drugs and [Prescription] [Generic] Drug products if all active ingredients are covered under this plan.]

[10.] [[Prescription] [Generic] Drugs used for Outpatient treatment of [Behavioral Health] [or] [Substance Abuse].]

[11.] [[Prescription] [Generic] Drugs used for contraception that are oral contraceptives, contraceptive patches, contraceptive vaginal rings or diaphragms. Injectable contraceptives and contraceptive implants are not covered.]

[12.] [Specialty Pharmaceuticals that are authorized by Us to be paid under the Outpatient Prescription Drug Benefits section [and are obtained through a [Participating Pharmacy] [or] [Specialty Pharmacy Provider].]

[**Manufacturer's Packaging Limits**
Some Prescription Drugs [or Therapeutic Classes of drugs] may be subject to additional supply, quantity, duration, gender, age, lifetime, cost sharing or other limits based on the manufacturer's packaging, plan limits or the Prescription Order. Examples of these situations are:

[1.] [If a Prescription Drug is taken on an as-needed basis, only enough medication for a single episode of care may be covered per Prescription Drug Copayment][; or]

[2.] [If two or more covered Prescription Drug products are packaged and/or manufactured together, the Covered Person may be required to pay a Prescription Drug Copayment and Prescription Drug Coinsurance amount for each of the Prescription Drug products contained in the packaging and/or in the combination Prescription Drug product][; or]

[3.] [If two or more Prescription Drug products are packaged and/or manufactured together and one or more of the active ingredients in the products are not covered, then the entire packaged and/or manufactured combination product is not covered under this plan].]

[Any Prescription Drug which is a metabolite, isomer, extended release or other dosage form, unique salt or other formulation, or other direct or indirect derivative of a Prescription Drug approved by the FDA may be subject to similar terms, limits and conditions of coverage or will not be covered by this plan if the original drug would not be covered.]]

PAYMENT OF BENEFITS

[**Participating Pharmacy**
Present the identification (ID) card to the Participating Pharmacy to obtain benefits. The Covered Person must pay any applicable [Coinsurance] [and] [Deductibles] [under the Medical Benefits section,] [Ancillary Charge,] [Prescription Drug] [Coinsurance,] [Prescription Drug] [Copayment] [and] [or] [Prescription Drug] [Deductible] to the Participating Pharmacy. The following additional cost sharing provisions apply to covered Outpatient Prescription Drugs purchased at a Participating Pharmacy when the ID card is used to obtain benefits:

[1.] [When a covered Generic Drug is available and that Generic Drug is received, the Covered Person pays the [Prescription Drug Copayment] [and] [or] [Contracted Rate] for that Generic Drug as shown in the [Benefit Summary] [Drug List].]

[2.] [When a Generic Drug is not available and a Brand Name Drug is received, the Covered Person pays the [Prescription Drug Copayment] [and] [or] [Prescription Drug Coinsurance] [and] [or] [Contracted Rate] for that Brand Name Drug as shown in the [Benefit Summary] [Drug List].]

[3.] [If a Brand Name Drug is received when a Generic Drug is available, the Covered Person pays the [Prescription Drug Copayment] [and] [or] [Prescription Drug Coinsurance] [and] [or] [Contracted Rate] for that Brand Name Drug, as shown in the [Benefit Summary] [Drug List], plus the difference in the Contracted Rate between the cost of the Brand Name Drug and the Generic Drug. The

difference in the Contracted Rate between the two drugs will not be reimbursed by Us nor does it count toward satisfying any Coinsurance, Deductible or other Out-of-Pocket Limit under the Outpatient Prescription Drug Benefits section [or the Medical Benefits section].]

[4.] [When a covered Prescription Drug is available under two or more names, dosages, dosage forms, dosage regimens or manufacturers' packaging [or when more than one covered Prescription Drug may be used to treat a condition that would be covered under this plan,] We will consider benefits only for the most cost effective drug, dosage form or packaging that would be a Covered Charge under this plan and that will produce a professionally adequate result.]

If the Covered Person does not use the ID card to obtain Prescription Drugs at a Participating Pharmacy, the Covered Person must pay for the Prescription Drugs in full at the Participating Pharmacy. To receive reimbursement for Covered Charges, the Covered Person must file a claim with Us as explained in the How To File A Claim provision in this section. [The Covered Person will be reimbursed at the Contracted Rate that would have been paid to a Participating Pharmacy for the cost of the covered Prescription Drug minus any applicable Ancillary Charge, Ancillary Pharmacy Network Charge, Coinsurance amount, Prescription Drug Copayment and/or Prescription Drug Deductible.] [The Covered Person will be reimbursed up to the Allowance for the cost of the covered Prescription Drug.] [Any Ancillary Charge, Ancillary Pharmacy Network Charge, Coinsurance amount, Prescription Drug Copayment, Prescription Drug Deductible and/or any amounts not paid by Us due to the difference between the billed amount for the Prescription Drug and Our benefit payment do not count toward satisfying any [Access Fee,] [Coinsurance,] [Copayment,] [Deductible] [or] [Out-of-Pocket Limit] under the medical portion [or the Outpatient Prescription Drug Benefits section] of this plan.]]

[**Specialty Pharmacy Provider**
A Covered Person must obtain authorization from Us before a Specialty Pharmaceutical is considered for possible coverage[, as outlined in the Utilization Review Provisions section]. If the Specialty Pharmaceutical is authorized, We will advise the Covered Person how the Specialty Pharmaceutical can be obtained from a Specialty Pharmacy Provider and how to file a claim with Us.]

[**Non-Participating Pharmacy**
When the Covered Person has prescriptions filled at a Non-Participating Pharmacy, the Covered Person must pay for the Prescription Drug in full at the Non-Participating Pharmacy. To receive reimbursement for Covered Charges, the Covered Person must file a claim with Us as explained in the How To File A Claim provision in this section. [The Covered Person will be reimbursed at the Contracted Rate that would have been paid to a Participating Pharmacy [or Specialty Pharmacy Provider] for the cost of the covered Prescription Drug minus any applicable Ancillary Charge, Ancillary Pharmacy Network Charge, Prescription Drug Coinsurance, Prescription Drug Copayment and/or Prescription Drug Deductible.] [The Covered Person will be reimbursed up to the Allowance amount for the cost of the covered Prescription Drug.] [Any Ancillary Charge, Prescription Drug Coinsurance, Prescription Drug Copayment, Prescription Drug Deductible and/or any amounts not paid by Us due to the difference between the billed amount for the Prescription Drug and Our benefit payment do not count toward satisfying any [Access Fee,] [Coinsurance,] [Copayment,] [Deductible] [or] [Out-of-Pocket Limit] under the medical portion of this plan.]]
RXP: 005.002.001.GE

- ***EXC: 110.001.GE is replaced with EXC: 110.001.001.GE, which reads as follows:***

[21.] [Charges for:

[a.] [A private duty nurse; a private duty professional skilled nursing service; a masseur, masseuse or massage therapist; a rolfer; a home health aide or personnel with similar training and experience; a stand-by Health Care Practitioner][, except as otherwise covered in the Outpatient Physical Medicine Services provision in the Medical Benefits section].]

[b.] [Home Health Care.]

[c.] [Treatment or services provided by a chiropractor.]

[d.] [Custodial Care; [respite care; rest care; supportive care;] homemaker services.]

[e.] [A Health Care Practitioner who is not properly licensed or authorized in the state where services are rendered.]

[f.] [[Phone consultations;] [internet consultations;] [e-mail consultations;] [Telemedicine Services;] [Telehealth Services].]

[g.] [Health Care Practitioner administrative expenses including, but not limited to, expenses for claim filing, contacting utilization review organizations or case management fees.]

[h.] [Missed appointments.]

[i.] [Sales tax; gross receipt tax.]

[j.] [Living expenses; travel; transportation[, except as otherwise covered in the [Professional Ground [or Air] Ambulance Services provision,] [Medical Evacuation Services provision,] [Repatriation Services provision] [or] [Transplants provision] in the Medical Benefits section].]

[k.] [Treatment or services that are furnished primarily for the personal comfort or convenience of the Covered Person, Covered Person's family, a Health Care Practitioner or provider.]]

EXC: 110.001.001.GE

- ***EXC: 175.001.GE is replaced with EXC: 175.001.001.GE, which reads as follows:***

[34.] [Charges for:

[a.] [Non-medical items, self-care or self-help programs.]

[b.] [Aroma therapy.]

[c.] [Meditation or relaxation therapy.]

[d.] [Naturopathic medicine.]

[e.] [Treatment of hyperhidrosis (excessive sweating).]

[f.] [Acupuncture; biofeedback; [neurotherapy;] electrical stimulation; or Aversion Therapy.]

[g.] [Inpatient treatment of chronic pain disorders.]

[h.] [Family or marriage counseling.]

[i.] [Applied behavior therapy treatment for autistic spectrum disorders.]

[j.] [Smoking cessation.]

[k.] [Snoring ~~[or sleep disorders, such as obstructive sleep apnea]~~.]

[l.] [The treatment or prevention of hair loss.]

[m.] [Change in skin pigmentation.]

[n.] [Stress management.]]

EXC: 175.001.001.GE

- ***EXC: 240.001.GE is replaced with EXC: 240.001.001.GE, which reads as follows:***

[47.] [Charges for drugs obtained from pharmacy provider sources outside the United States, except as otherwise covered in the [International Coverage,] [Travel Benefit,] [or] [~~Worldwide~~ World Wide Coverage] provision[s] in the Medical Benefits section.]

EXC: 240.001.001.GE

- ***EXC: 300.001.GE is replaced with EXC: 300.001.001.GE, which reads as follows:***

[59.] [Charges for treatment or services required due to Injury received while engaging in any hazardous occupation or other activity for which compensation is received including[, but not limited to,] the following: [Participating,] [or] [instructing,] [or] [demonstrating,] [or] [guiding] [or] [accompanying others] in [parachute jumping,] [or] [hang-gliding,] [or] [bungee jumping,] [or] [racing any [motorized] [or non-motorized] vehicle,] [skiing] [or] [horse riding] [or] [rodeo activities]. Also excluded are treatment and services required due to Injury received while practicing, exercising, undergoing conditioning or physical preparation for any such compensated activity[, unless otherwise noted as a Covered Charge in this plan].]]

EXC: 300.001.001.GE

- ***PRE: 030.001.GE is replaced with PRE: 030.001.001.GE, which reads as follows:***

[**Reinstatement**
If any premium is not paid within the required time period, coverage for You [and any Covered Dependents] will lapse. The coverage will be reinstated if all of the following requirements are met:

[1.] [The lapse was not more than [30 days].]

[2.] [You submit a [supplemental] enrollment form for reinstatement to Us along with the required premium payment. Submission of premium to Your agent is not submission of premium to Us.]

[3.] [We approve Your [supplemental] enrollment form for reinstatement.]

The coverage will be reinstated on the date We approve Your enrollment form for reinstatement. [If We have not responded to Your enrollment form for reinstatement by the 45th day after We receive the enrollment form, the coverage will be reinstated on that date.]

[If the coverage is reinstated, loss resulting from an [Injury] [or] [Sickness] will be covered only if the [Injury] [or] [Sickness] is sustained on or after the date of reinstatement.] [Loss due to a Sickness will be covered only if the Sickness begins [more than] [10 days] after the date of reinstatement.] No benefits will be paid for such condition and related complications if during the time between the lapse date and the reinstatement date:

[1.] [Medical advice, consultation, diagnosis, care or treatment was sought, received or recommended from a provider [or Prescription Drugs were prescribed] regardless of whether the condition was diagnosed or not diagnosed; or]

[2.] [The condition produced signs or symptoms.]

[The signs or symptoms were significant enough to establish manifestation or onset by one of the following tests:

[a.] [The signs or symptoms reasonably should have allowed or would have allowed one learned in medicine to diagnose the condition; or]

[b.] [The signs or symptoms reasonably should have caused or would have caused an ordinarily prudent person to seek diagnosis or treatment.]

This limitation will apply until coverage has been in force for [12 months] after the reinstatement date, unless the condition has been specifically excluded from coverage.

In addition, death occurring between the lapse date and the reinstatement date will not be covered under the Life Insurance Benefits section.

In all other respects, You and Our Company will have the same rights as existed under this plan before the coverage lapsed[, subject to any provisions included with or attached to this plan in connection with the reinstatement].]]

PRE: 030.001.001.GE

- ***OTH: 041.001.GE is added:***

[**Deductible Credit Program**

[[Beginning the earlier of the [January 1st –December 31st] [or] [January 1st –December 31st] that next follows the [[30th-365th] [day] [[0-12] [months] after Your Effective Date, You will receive a [5%-20%][$XXX] credit to Your [Individual] [Family] [Integrated] [and] [Network] [Participating][,][and] [Non-Network] [Non-Participating] Deductible for each [[0-12]-month] period during which the Deductible less any accumulated credits has gone unsatisfied.] [Each [5%-20%][$XXX] credit will be based on Your [Individual] [Family] [Integrated] [and] [Network] [Participating][,][and] [Non-Network] [Non-Participating] Deductible [less any accumulated credits].] [At no time will Your [Individual] [Family] [Integrated] [and] [Network] [Participating][,][and] [Non-Network] [Non-Participating] Deductible less any accumulated credits be less than [$XXX].]]

[When Covered Charges equal to the [Individual][or] [Family][or] [Integrated] [and] [Network] [Participating][,][and] [Non-Network] [Non-Participating] Deductible less any accumulated credits have been Incurred and processed by Us, the [Individual][or] [Family][or] [Integrated] [and] [Network] [Participating][,][and] [Non-Network] [Non-Participating] Deductible will be satisfied for the remainder of that Calendar Year.] [On January 1st of the following Calendar Year, You will return to the [Individual][or] [Family][or] [Integrated] [and] [Network] [Participating][,][and] [Non-Network] [Non-Participating] Deductible amount, as shown on Your Benefit Summary.]]]

[This Deductible Credit Program may be discontinued at any time by providing You with a prior [30-180]-day notice.]]

OTH: 041.001.GE

- ***OTH: 041.002.GE is added:***

[**Deductible Reward Program**

[[You will receive a [one-time] [5%-25%][$XXX] Deductible [credit] [reward] [monthly] [quarterly] [semi-annually] [annually] [at renewal] to Your [Individual][or] [Family][or] [Integrated] [and] [Network] [Participating][,][and] [Non-Network] [Non-Participating] Deductible [if [during a [[6-24]-month] period]] Your [Individual][or] [Family][or] [Integrated] [and] [Network] [Participating][,][and] [Non-Network] [Non-Participating] Deductible has not been satisfied.] [At no time will Your [Individual][or] [Family][or] [Integrated] [and] [Network] [Participating][,][and] [Non-Network] [Non-Participating] Deductible less any

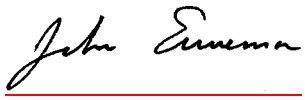
accumulated [credits] [reward] be less than [$XXX][or the minimum HSA-Qualified deductible amount for HSA-Qualified plans].]]

[This Deductible Reward Program may be discontinued at any time by providing You with a prior [30-180]-day notice.]]
OTH: 041.002.GE

- ***OTH: 041.003.GE is added:***

[Multi Year Deductible
[[You will receive a [one-time] [5%-25%][$XXX] Deductible [credit] [reward] [monthly] [quarterly] [semi-annually] [annually] [at renewal] to Your [Individual][or] [Family][or] [Integrated] [and] [Network] [Participating][,][and] [Non-Network] [Non-Participating] Deductible [for a [18-60][-month period] [for the period shown on the benefit summary] [if [during a [[6-24]-month] period]] Your [Individual][or] [Family][or] [Integrated] [and] [Network] [Participating][,][and] [Non-Network] [Non-Participating] Deductible has not been satisfied].] [At no time will Your [Individual][or] [Family][or] [Integrated] [and] [Network] [Participating][,][and] [Non-Network] [Non-Participating] Deductible less any accumulated [credits] [reward] be less than [$XXX][or the minimum HSA-Qualified deductible amount for HSA-Qualified plans].]]

[This Multi Year Deductible Program may be discontinued at any time by providing You with a prior [30-180]-day notice.]]
OTH: 041.003.GE



Secretary